

# PHILADELPHIA MEDICAL TIMES.

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## ORIGINAL COMMUNICATIONS.

### WINTER HEALTH-RESORTS—THE CLIMATE OF ATLANTIC CITY, AND ITS EFFECTS ON PULMONARY DISEASES.

BY BOARDMAN REED, M.D.,  
Atlantic City, N.J.

WHERE shall we send our invalids for a change of air in winter? This is a practical question which is becoming, year by year, more important to busy physicians, particularly in the great cities of the North. There are certain chronic diseases for which a pure and invigorating air, and especially a climate which will tempt the patients out of doors, are highly desirable. For many cases a change to such an air offers the best hope of cure, or even of amelioration.

Florida has been much in vogue lately as a winter-resort, and undoubtedly suits numerous patients well; but it is too far away, involving a long and tiresome journey. The distance from home and friends, and the impossibility of conferring in an emergency with the usual medical attendant, are serious inconveniences. The prevalence of malaria there is a source of danger, and the very warm and enervating character of the Southern climate unfits it for a large class of diseases altogether.

Colorado and Minnesota are even farther away, and their climates, however tonic and useful, are so cold that invalids there can live very little out of doors during the winter; and if they are to be kept prisoners in close heated rooms it might almost as well be in their own homes.

Northern Africa and Southern Europe, especially Pau, Nice, Mentone, and other places along the northern shore of the Mediterranean, are just now in great repute. Invalids are flocking thither every winter, and, the impartial chroniclers tell us, are leaving their bones in the cemeteries there in sadly large numbers.

Dr. Madden, in his "Health-Resorts of Europe and Africa," says, "With one exception the most frequented winter health-resort in Europe is Pau;" then proceeds to denounce the climate as "essentially

cold, variable, damp, and dreary during the winter." During one December while he was there he states that "the thermometer fell eleven times to zero."

Dr. John Parkin, in his work on "Climate and Phthisis," is equally emphatic in condemning that climate, saying, among other things, that "of a number of patients I have known who passed a winter in Pau, not one received any benefit,—the majority died soon after their return."

As to Nice and Mentone, Dr. Madden quotes several medical travellers and former resident physicians to the effect that these places are exposed to very sudden changes of temperature, and that the native residents are very subject to pulmonary complaints, which with them are apt to run a rapid course. Dr. Parkin, in the work already quoted, is particularly severe upon the climate of those places, stating that though it is usually very warm there in the sun, insomuch that umbrellas are indispensable, it is apt to be cold in the shade, necessitating the heaviest wraps. Crossing the street is like passing from summer to winter. The same author shows that, from the location of these towns in the neighborhood of mountains, some of whose tops are always covered with snow in winter, they must be continually subject to cold, raw winds, which are all the more intolerable and dangerous because of the heated air which they displace.

Says Dr. Parkin, "During January and February, then, there would be two cold winds prevailing at Mentone, as is frequently the case at Nice. It is not surprising, therefore, that I should have left the latter town in the month of March in a snow-storm, or that snow should have fallen heavily all the way to Genoa."

Dr. J. H. Bennett, of Mentone, the chief eulogist of that climate, insists very strenuously upon certain precautions against taking cold. "Without them," he says, "it is unsafe and treacherous. This is evidenced by the great mortality of the natives of the Nice and Mentone districts by pneumonia and pleurisy, two of the commonest maladies."

Dr. Parkin's conclusion is that the Riviera is "one of the most unfavorable and dangerous climates for chronic diseases of the respiratory organs, and especially for phthisis." As to Africa, he cites army reports showing that "of the British troops

passing through Egypt during 1872 *en route* for India, 29.9 per 1000 were attacked with phthisis and 2.3 per 1000 died." He adds, "When it is remembered that these patients manifested no symptoms of the disease when they left England, otherwise they would have been detained, this result speaks trumpet-tongued as regards the influence of such a climate in the development of phthisis."

If these are the most desirable winter-resorts in the Old World, American invalids, especially those suffering from chronic pulmonary affections, would do well to remain on this side of the ocean.

Atlantic City, New Jersey, a place most favorably located as regards convenience of access, being less than two hours' ride from Philadelphia by any one of three railroads, and only four hours from New York by the Pennsylvania Railroad and its West Jersey branch line, possesses certain physical advantages which are well worth considering. It has been twenty years or more since physicians began sending patients here in winter. First only now and then a courageous invalid ventured here at this season, but their numbers steadily increased. The experiment proved so successful in hastening the convalescence from acute disease, in improving a large class of chronic affections, and especially in arresting numerous cases of incipient as well as confirmed consumption, that within the last three years the travel to the place in winter has reached very considerable proportions, and the numerous thoroughly heated winter hotels—some of which are as sumptuously furnished and as luxuriously conducted as the leading houses at the summer-resorts—are crowded with invalids, convalescents, and wearied society people through all the months from January on.

Actual experience has demonstrated that sea air is as valuable in winter as in summer. It also bears out the statistics which prove that the climate of Atlantic City is superior to that of most sea-coast towns, being drier, more equable, and, considering the latitude, unusually mild.

The city—for it is in fact as well as in name a city, having a permanent population of six thousand, and being supplied with gas, street-cars, etc.—is situated in latitude 39° 22', on an island ten miles long and averaging about half a mile wide. This is separated from the mainland at

either end by broad bays or inlets, which are connected by a narrow arm of the sea called "The Thoroughfare." There is no body of fresh water nearer than the Delaware River, distant about sixty miles, and the salt-water bays to the landward side are nearly always open, ice seldom forming, except for a short time occasionally in the severest winters.

Another peculiarity of the location is that all the winds from the landward must pass for long distances—hundreds of miles in some directions—over a very dry and porous sandy soil upon which snow rarely lies for any time. These winds, including those from the north, northwest, west, and southwest, are therefore to some extent both dried and warmed in their passage.

Though the coast of Southern New Jersey has a general direction from northeast to southwest, the beach at Atlantic City trends more to the westward, so that it faces almost directly southward. Therefore south as well as east winds are sea-breezes here, and both blow across the Gulf Stream, which, by the way, exercises considerable influence upon the climate of this part of the coast.

Mr. C. P. Patterson, Superintendent of the United States Coast and Geodetic Survey Office at Washington, has kindly furnished me with a large map indicating accurately the course of the Gulf Stream, and with some interesting facts concerning it.

This map shows at a glance that the heated waters of the tropics, pouring through the space between Cuba and Florida, flow in a northeasterly direction along the coast of Georgia and the Carolinas, diffusing themselves as they go, until from a compact stream less than fifty miles wide, they have become opposite Chesapeake Bay a broad expanse upwards of four hundred miles in width. This really includes numerous parallel or slightly diverging currents of very warm water with overflow currents of a somewhat lower temperature. One of these overflow currents approaches within sixty-five miles of Atlantic City, while it is one hundred and ten miles from Sandy Hook. The principal current is farther away, being one hundred and thirty-five miles from Atlantic City, one hundred and eighty-five miles from Sandy Hook, and about the same distance from Long Branch and Montauk Point.

But the exceptional mildness of this

climate may be attributed to the peculiar course of the Gulf Stream in this vicinity as much as to its proximity. The innermost current, according to the map received from the Coast Survey Office, has a direction opposite Atlantic City of east-north-east, but turns more and more to the eastward till in latitude  $40^{\circ}$ —that of Philadelphia—it bears nearly due east. The main current turns more abruptly, and a little north of latitude  $38^{\circ}$ , some distance to the southward of Atlantic City, has a course directly eastward. Our south, south-east, and east winds, then, must all pass for three hundred to five hundred miles at least over more or less heated water which has come directly from the Gulf of Mexico. Our only ocean breezes not affected in this way are those from the northeast, and experience shows that these are the only winds which are generally unpleasant here. But for places farther up the coast, particularly those north of latitude  $40^{\circ}$ , the case is different. Neither their northeast

nor east winds can be appreciably modified by the Gulf Stream. Their south and southeast winds may be favorably influenced to some extent, but less than are the same winds at Atlantic City, since they pass over a much larger surface of cold water after crossing the Gulf Stream. It may be added that some small maps issued by the Signal Service Office represent the Gulf Stream as occupying different positions in winter and summer, but on this point Mr. Patterson writes, "I greatly doubt if there can be any material change of the stream from season to season; at least there has been no reliable evidence obtained on that subject."

To Sergeant E. W. McGann, who has charge of the United States Signal Station at Atlantic City, I am indebted for meteorological statistics and official records, from which the following information, bearing directly upon the subject of the climate of the place, has been condensed and tabulated:

TEMPERATURE, HUMIDITY, BAROMETRICAL PRESSURE, AND RAIN-FALL AT ATLANTIC CITY, NEW JERSEY.

Months, 1880.	Mean temperature.	Range of temperature.		Mean humidity.	Mean barometer.	Rain-fall, in inches.
		Max.	Min.			
January.....	41.1	64	13	79.3	30.189	1.70
February.....	38.2	71	11	74.4	30.129	2.85
March.....	40.1	72	18	71.9	30.061	5.97
Mean for three months..	39.8	.....		75.2	30.126	10.52

The mean temperature for January, February, March, and December, the four coldest months of the year, was, in 1879,  $34.7^{\circ}$ ; in 1878,  $36.8^{\circ}$ ; and in 1877,  $35.9^{\circ}$ .

The prevailing winds in winter are those from the west and northwest, which are usually dry and bracing. The east and south winds, which often blow for days at a time, are warmer and more humid. Northeast winds, which are unpleasant, usually prevail for two or three days at the time of the equinoctial storms, but are infrequent during the remainder of the year.

Observations taken at my office, in the centre of the town, at 7 A.M., 12 M., and 6 and 10 P.M., show that in December, 1879, there were twenty-six days during which the thermometer did not fall below  $32^{\circ}$ ,—the freezing-point; also that there

were only two days in the same month when the thermometer did not indicate at noon a temperature above  $40^{\circ}$ ; and that there were ten days upon which it was not below  $50^{\circ}$  at the same hour. During the January following (1880) there were twenty-four days during which the mercury never fell below the freezing-point at any hour, and only two days during which it went below  $30^{\circ}$ . It was only once in the same month lower than  $40^{\circ}$  at noon, and only three times lower than  $45^{\circ}$  at the same hour. On nineteen of the thirty-one days the thermometer stood at  $50^{\circ}$  or above at mid-day.

These mid-day temperatures are obviously more important than averages, for it is in the daytime that invalids take their airing out of doors.

The dryness of this climate, as compared with other sea-side resorts, is best

shown by the statistics of the rain-fall, which is less here than at any other place on the coast, as appears from the table given below. The readings of the hygrometers at the different stations are not so significant, since at some of them, including Atlantic City, the instruments are located so near to the beach, and at so low an elevation above the sea-level (less than thirteen feet here), as to be affected by the spray, during strong winds, off the water, and by occasional morning mists, which do not extend back into the town.

*ANNUAL AMOUNT OF RAIN-FALL AT THE PRINCIPAL CITIES AND STATIONS ON THE ATLANTIC COAST.*

Stations.	Year ended June 30, 1879.	Year ended June 30, 1878.
Atlantic City, N.J.....	40.60 inches.	42.90 inches.
Barnegat, N.J.....	49.38 "	52.35 "
Boston, Mass.....	62.96 "	54.50 "
Cape May, N.J.....	42.44 "	47.99 "
Charleston, S.C.....	64.33 "	68.62 "
Galveston, Texas.....	51.03 "	67.47 "
Jacksonville, Fla.....	51.62 "	52.11 "
Newport, R.I.....	52.20 "	55.84 "
New Orleans, La.....	58.29 "	73.31 "
New York, N.Y.....	43.68 "	42.68 "
Norfolk, Va.....	44.44 "	66.28 "
Portland, Me.....	41.10 "	45.61 "
Sandy Hook, N.J.....	60.37 "	54.86 "
Savannah, Ga.....	55.14 "	52.44 "
Wilmington, N.C.....	50.90 "	84.12 "

The mean barometer for the year ended June 30, 1879, was higher at the Atlantic City station than at any other on the coast north of Chesapeake Bay, and, with one or two exceptions, the same may be said as to the preceding year. This is a matter of importance, since depressions of the barometer affect the majority of invalids far more decidedly and injuriously than low temperatures. An extra wrap out of doors or a fire in-doors will perfectly antidote any ordinary degree of cold, but it is far more difficult to render comfortable the invalid whose breathing is distressed or whose joints and nerves have been set to aching by a sudden fall in the atmospheric pressure. Barometrical changes are also connected intimately with variations in the electrical conditions of the atmosphere, and these again strongly impress the delicate nervous systems of the sick.

In the following table the figures represent the average atmospheric pressure for the years named *at the sea-level*, allowances having been made for differences in the elevation of the stations:

*TABLE SHOWING MEAN BAROMETER AT VARIOUS STATIONS.*

Stations.	Year ended June 30, 1879.	Year ended June 30, 1878.
Atlantic City.....	30.031	30.002
Barnegat.....	30.029	29.998
Boston.....	29.975	29.969
Cape May.....	30.029	30.007
Galveston.....	30.049	29.995
Jacksonville.....	30.079	30.030
Newport.....	29.993	29.980
New York.....	30.026	30.006
Portland, Me.....	29.944	29.952
Sandy Hook.....	30.014	30.000

After all, however, it is with climates as with medicines,—trustworthy evidence as to what they have accomplished is the most valuable. With regard to nervous, rheumatic, gouty, dyspeptic, and various other chronic ailments (including most of those peculiar to women), which are usually found to be benefited here in the summer, equal benefit may be expected in the winter. Convalescents from acute disease, or from surgical operations, nearly always improve remarkably upon being removed to this place from the large cities.

As to diseases of the respiratory organs, I have had personal knowledge of many patients suffering from all the forms of such affections who have made trials of this climate in winter. The bronchial and laryngeal cases have, as a rule, improved, some of them very decidedly, though there have been exceptions. The consumptives who were in the third stage, or in any stage with evidences of actively progressing disease of the lung and decided hectic, have only exceptionally been benefited. Those, however, in the pre-tubercular or incipient stage, and those even in the advanced stages where the destructive process has been advancing slowly, have often experienced very marked improvement. In a considerable proportion, about one-fourth, of these latter classes of cases the disease has been apparently arrested, and some of them seem to be cured.

Detailed reports of the cases I have treated at Atlantic City would fully bear out the foregoing general conclusions, but would unduly extend this paper and necessitate the exclusion of several reports I have received from prominent Philadelphia physicians concerning the effect of this climate upon their patients in winter especially. Some of these physicians have been sending patients hither for more than



twenty years. Their testimony is more valuable than mine, and cannot be impugned on the ground of partiality.

It is a significant fact that pneumonia and bronchitis are of infrequent origin here, and when they do occur the patients *almost invariably recover*. Upon this point my experience as a resident physician enables me to speak very positively. I have not known an uncomplicated attack of either disease to prove fatal.

The reports from physicians above referred to were received in response to inquiries recently sent to them. Many others wrote brief apologies, not having the notes or the leisure to tabulate the results of their experience as I had requested. Only one physician objected to the climate either for bronchitis or early phthisis.

Dr. Laurence Turnbull writes, "The number of cases of phthisis that I have sent to Atlantic City have been few in the last stages, as I found they were not improved by a residence at the sea-shore, dry even as it is," adding that a few cases in those stages were aggravated, but goes on to say, "I have been much pleased with its influence on the first stages of phthisis, asthma, laryngitis, bronchitis, and nasal catarrh, when all ordinary means have failed in the city, by causing improvement in the appetite, assisting the digestion, and giving a healthier tone to the skin. In convalescence from catarrhal pneumonia and typhoid fever the results have been most gratifying. In certain forms of *otitis media purulenta* I do not find the air of Atlantic very beneficial, and in many cases diseases of the ear are caused by exposure of that organ to the waves. In strumous diseases of eyes, joints, limbs, etc., I have found the change to Atlantic City, if persisted in for several seasons, of permanent benefit."

Dr. Thomas J. Yarrow writes, "It has not been my practice, as a rule, to advise patients suffering with tuberculous and other diseases of the respiratory passages to sojourn at the sea-side. Exceptionally, I have had them go to Atlantic City, and have known cases of incipient phthisis, chronic bronchitis, asthma, and laryngitis to improve in that location. My experience of late is inducing me to recommend a larger number of such cases to reside at Atlantic City."

Dr. Thomas G. Morton thus bears testimony: "I have been in the habit of send-

ing to the shore at Atlantic City many patients, more especially surgical cases, but a large number also of those with lung affections, and especially those having a (hereditary) tubercular disposition, and I think especially such cases have been vastly benefited by the sojourn."

Dr. James Darrach, of Germantown, writes, "Have sent several cases of autumnal catarrh to Atlantic City, and think without exception they were benefited, two of them being certainly exempt from these attacks while at the shore. The only case of slow convalescence from pneumonia died at Atlantic City. This was about twenty-three years ago. A case of obstinate general bronchitis was cured in about ten days. A case of what I supposed to be tubercular laryngitis was very much benefited, and subsequently recovered. I have also had other cases of obstinate catarrh which returned well after a sojourn at Atlantic City."

Dr. Eugene P. Bernardy reports as follows: "With but one exception, all my cases of phthisis, both in the early and late stages, amounting to twelve in all, have been decidedly benefited by a sojourn at Atlantic City, and one case positively cured,—that is, as far as human ear can ascertain. Of the three cases of convalescence from pneumonia all were decidedly benefited. In a child suffering from chronic pneumonia the lung in a few weeks was almost entirely cleared up. In bronchial affections (chronic) I have seen no permanent benefit in any of the six cases I have sent there: all benefited while at the sea-shore, but a few months after their return relapsed. The case of phthisis cured had been examined by myself and Dr. Hall in Philadelphia, and while at the sea-shore examined by Dr. L. Turnbull. We all diagnosed incipient phthisis. This was nearly six years ago. On her return she had gained forty pounds, and has remained well ever since."

Dr. John H. Packard says, referring to Atlantic City, "I can only say that I frequently advise convalescents to go there, and that it is a very common thing with me to be asked by patients whether it would not do them good to spend a week or two there. I do not now recollect any case that has been wholly without benefit from that climate, and could adduce many that have gained great advantage from it."

Dr. D. Murray Cheston writes, "I can-

not say how many cases of pulmonary or bronchial troubles I have sent there, but the general result has been most satisfactory. The cases were all sent in the late winter or early spring months, and have invariably returned improved."

Prof. J. M. Da Costa writes briefly, as follows: "I have sent too few patients with pulmonary disease to Atlantic City to have the data to answer your questions. Some who were in a run-down condition and affected with chronic bronchial catarrh did very well."

Dr. Ellwood Wilson writes that in the summer months he does not think patients with fully-developed phthisis improve by a protracted residence at Atlantic City, but adds, "During the winter months—say from October to July—I regard it as a very favorable locality for consumptive patients."

Dr. R. J. Lewis writes that his practice (being almost exclusively surgical) "is not of a kind to furnish experience with regard to the beneficial influence of Atlantic City in pulmonary affections," but that he has "a good opinion of its dry and mild climate."

Dr. James J. Levick has not sent any cases of phthisis, but has sent "several cases of laryngeal and bronchial irritation and one or two cases of hay asthma, which improved greatly while at Atlantic City." He adds, "The cases which have derived most benefit, however, and of which I have sent not a few in the late winter months, have been patients after typhoid fever,—patients whose nervous systems have been much disturbed, persons who have needed brain rest, etc."

Dr. Wm. H. Bennett, resident physician at the Children's Sea-shore House and Sea-side House for Invalid Women at Atlantic City, contributes the following full report: "My experience of the effects of a sojourn at Atlantic City upon those suffering from pulmonary diseases has been confined to what I have seen among transient visitors during the summer months of the past seven years. I have had little or no experience of the effects either of a prolonged stay or of a stay in winter. I cannot give you exact figures, but the following is a fair statement of what I have observed. My patients were, with the exception of a majority of those suffering from phthisis, nearly all children. I have had not less than a hundred cases of acute bronchitis,

nearly all of which ran a milder and shorter course than similar cases do in Philadelphia. The majority of these cases had during treatment the best possible hygienic surroundings, but a few which were much exposed during cool, rainy weather in leaky, damp apartments seemed to do equally well. A few, perhaps ten, cases of subacute bronchitis which had remained stationary in the city for some time rapidly recovered at the sea-shore. Three or four cases of chronic bronchitis, with emphysema and occasional severe attacks of asthma, greatly improved; but about an equal number showed no change. Two or three cases of tardy convalescence from pneumonia made much more rapid progress towards recovery after their removal to the sea-shore. Two cases of empyema with external fistulæ greatly improved. About twenty cases of phthisis have been under my care at Atlantic City. These have been in all stages of the disease. A very few, I recall but three, derived no benefit; all the others improved in general health. In some, even of the advanced cases, the improvement was marked. In many of the cases the cough became less troublesome and the breathing less labored. Nearly all slept better. Hectic frequently disappeared entirely, or was greatly lessened. These cases, with two exceptions, remained too short a time to allow of any inference in regard to the effect of their stay upon the progress of the disease itself. One of these two exceptional cases remained three months. It was one of the few that did not improve at all, and the disease ran its usual course. The other spent most of the time during the last eighteen months of his life at Atlantic City, and his downward progress was undoubtedly much retarded by so doing. I am aware that the experience which I have thus detailed has been too meagre, except perhaps in the cases of acute bronchitis, to allow of any general conclusions. But, after comparing my own experience with that of others, I am convinced that the atmosphere of Atlantic City in summer (perhaps also in winter, but I do not know) will prove especially beneficial in the large majority of cases of diseases of the respiratory organs, and that the very common opinion that the sea-coast is everywhere unsuitable for cases of phthisis has little foundation. So thoroughly am I convinced of this fact that I

am striving to have special provision made in the Sea-side House for Invalid Women for consumptives, and in doing so I am but following in a small way the example set by the establishment of the magnificent Royal National Hospital for Consumption on the sea-coast of the Isle of Wight."

The good accomplished by this climate I attribute not to any specific influence of the air upon the lungs, but to its tonic and alterative properties, acting by the improvement of digestion and nutrition, the promotion of sleep, etc. Atlantic City is the most accessible to the New England and Middle States of any place having claims as a winter-resort and admitting of outdoor exercise for most invalids the whole winter through.

## TWO EXAMPLES OF PURPURA HÆMORRHAGICA FROM WIDELY DIFFERENT PRIMARY CAUSES.

BY WALTER C. STILLWELL, M.D.

**C**HAS. H., æt. 8, while playing in a stable-yard was incarcerated in a dung-pit by his playmates for about twenty minutes to half an hour, and a few hours after being liberated he was seized with a chill, followed by the appearance of red spots over the whole body, which gradually became of a purple color, and soon after he began to have hemorrhage from the nose, which was very profuse and lasted for some considerable time; he became exceedingly weak, his pulse grew feeble and very rapid, and for a time his condition was very alarming. On making an examination of his throat, I found the tonsils so much enlarged that they almost filled up the fauces; they were of a dark-purple color, and looked as if the blood was about to start from them. The other portion of the mucous membrane of the mouth and throat was very pale and unnatural in color.

Attention was first directed to stopping the hemorrhage, which was done after much difficulty; the various vegetable and mineral astringents were used without effect, and, as a last resort, I was compelled to plug the nostrils with cotton saturated with a strong solution of alum.

The tinct. ferri chlor. with potass. chlorat. in large doses was administered internally, in conjunction with strong milk-punch. This treatment was continued for about five days, when the sulphate of quinia was added to the other medicinal agents. A week or ten days passed before I considered him in a fit condition to leave.

The other case was that of a little girl, 9 years of age, who was a typhoid fever patient,

the purpuric spots appearing about the tenth day of the attack, accompanied by a profuse bleeding from the nose, as in the other case, and after a day or two cerebral symptoms set in and the child died.

Here are two cases of purpura hæmorrhagica, with the extravasation of blood in or upon the true skin, appearing in spots over the whole body: both are caused by a depraved or poisoned state of the blood and the relaxed condition of the capillary vessels.

In the first case, the child inhaled the ammoniacal and other putrescent vapors from the refuse matters in the pit, and the inoculation or absorption of the poison was through the respiratory apparatus; but in the second case, the typhoid fever patient, it occurred through the medium of the bowels, the matters from the diseased glands of Peyer being absorbed into the blood.

## INTERNAL ADMINISTRATION OF NITRITE OF AMYL AS A STIMULANT IN THE TYPHOID STATE.

BY JOHN M. KEATING, M.D.

**I** REPORT the following not because I deem the matter contained therein conclusively proven by the case narrated, but simply to encourage those who have the opportunity to investigate still further in what may become an important field in therapeutics.

My case was carefully and intelligently watched by the then resident physician, Dr. Philips, and the reports submitted are mainly taken from his notes at the time.

I. O., a colored man, aged 32 years, was admitted to the medical wards, Philadelphia Hospital, on Monday, March 4, 1878, at 11 A.M. He stated that he had been taken with a violent chill on Friday night, followed by fever and copious perspiration. On Saturday and Sunday he was chilly and unwell, had a dry, hard cough, a severe headache, and spat blood.

After his admission his condition was as follows. Respiration 66, very shallow; a severe, constant pain, increased in severity by the slightest effort, felt at base of left lung; this pain radiated to apex of same side. Hasty examination revealed marked dullness on side and back of left lung. At this point breathing was tubular, and at the margins, with deep inspiration, crepitant râles. At right apex there was dullness, prolonged expiration, which at the time was noted as a chronic trouble.

The base of the right lung was normal, though somewhat exaggerated, as probably most of the aeration was done by this lung. The temperature was  $104^{\circ}$ , and the pulse 110. He was ordered wet cups over left lung posteriorly, and dry cupping *ad libitum* over whole thorax. This was followed by a poultice. A moderate dose of opium with ten grains of quinia was given at once.

The case was recorded as one of acute pleuro-pneumonia in first stage, affecting the left lung in an anæmic adult negro, with consolidation of the apex of right lung that had not yet begun to break down. At three o'clock P.M., owing to the weak pulse and general evidences of great prostration, stimulants were indicated. The pains had somewhat abated, the sputa were free and were well tinged with blood. The temperature had gone up to  $106^{\circ}$ .

No form of stimulants, for some reason, could be obtained. It occurred to me to use *nitrite of amyl*, which I had heard had been used to prolong the "*stadium alcoholicum*" by some devotees.

Three drops of the nitrite were ordered in emulsion every three hours, and all other medication stopped.

At nine next morning the patient was reported as decidedly more comfortable. The temperature was still high,  $105\frac{2}{3}^{\circ}$ ; the pulse had fallen to 96, was good, full, and regular; respirations were 50, easy, and deeper; the pain was not severe. He had taken four doses of the nitrite mixture.

I give below his temperature record for four days and nights, after which he continued to improve until he got entirely well of the pleuro-pneumonia and nothing remained but the consolidated right apex.

Up to 10 A.M. on the 6th, the third day after his admission, he had taken twelve doses of the nitrite of amyl, no alcoholic stimulants, and no other medicine of any kind.

March 5.—10 A.M., pulse 96, resp. 32, temp.  $105\frac{2}{3}^{\circ}$ ; 2 P.M., temp.  $104\frac{2}{3}^{\circ}$ ; 6 P.M., temp.  $105\frac{1}{2}^{\circ}$ ; 6 P.M., temp.  $104^{\circ}$ ; midnight, pulse 98, resp. 30, temp.  $103\frac{2}{3}^{\circ}$ .

March 6.—10 A.M., temp.  $103^{\circ}$ ; 2 P.M., temp.  $102\frac{2}{3}^{\circ}$ ; 9 P.M., pulse 90, resp. 42, temp.  $102^{\circ}$ ; midnight, temp.  $102\frac{1}{3}^{\circ}$ .

On the 7th, the fourth day after admission, the temperature varied between  $102^{\circ}$  and  $103^{\circ}$ ; the pulse went down to 88.

On the 8th the temperature did not go higher than  $100\frac{3}{8}^{\circ}$ , the pulse registered 84, and the respirations were 36.

For several days the nitrite of amyl was given three times daily, and occasional doses were administered until auscultation and percussion showed that air was freely entering the lung. In this case there was from the commencement a tendency towards the typhoid state, and the very rapid improvement which ensued from the treatment was attributed to the nitrite of amyl as the only drug given.

## NOTES OF HOSPITAL PRACTICE.

### LOUISVILLE HOSPITAL COLLEGE OF MEDICINE.

CLINICAL SERVICE OF DUDLEY S. REYNOLDS, M.D., PROFESSOR OF OPHTHALMOLOGY AND OTOTOLOGY IN THE HOSPITAL COLLEGE OF MEDICINE.

Reported by A. H. KELCH, M.D., Stenographer.

#### ON THE EYE.

(Continued from page 143.)

**CASE V.**—Mrs. K., aged 59 years, comes here with a tumor in the upper margin of the left brow. It is hard and at times painful. The skin covering it is glossy and tense. It is a steatoma or sarcoma, and I shall remove it. Making an elliptical section of the tense skin, we see a pulpy, semi-translucent mass of cellular substance, not unlike brain-substance. I think it is medullary cancer, of the encephaloid variety. It is developed by a peculiar retrograde metamorphosis of the cells composing the tissue in which the morbid growth is developed. What condition determines the retrograde metamorphosis of cells is something that has not yet been discovered. A cancer is primarily of local origin, affecting the system secondarily through the agency of the lymphatic glands, which become obstructed, and through the colliquative discharges from rapid suppuration. The neighboring glands here are already infiltrated with cancer-cells, no doubt. That being the case, we cannot, of course, hope to eradicate this affection from the system by the operation I have just performed. I believe in Henry Arnott's theory of the local origin of cancer. The popular opinion is that cancer is a kind of parasitic growth, and it is inferred, from its common name, that it is a kind of crab. It has long since been determined that the microscope does not reveal any special kind of cell as characterizing a growth of what is termed cancer. There is no specific cancer-cell, but we recognize a tumor as cancerous in which embryonic cells predominate. Then the nature of a cancer is this, that the cells which form the normal tissue, instead of going on in the process of development, assume the form of the cell in embryonic life, and these go on accumulating by proliferation or aggregation in the part until they become the predominating cell. If these cells are round, we call the tumor in which they are



found round-celled cancer; if they are very large, we call it a giant-celled cancer; and if star-shaped, stellate, which is the form, generally speaking, peculiar to melanotic cancer, black cancer, more frequently observed in the liver and lung. There are some forms characterized by filiform cells, and you are to understand that in any tissue of the body where the embryonic cell is formed, it means cancer, and the shape of the cell will depend much upon the tissue in which it is found.

Its essential pathology consists in a retrograde process of the cell-change, which finally undergoes fatty degeneration, and in other instances the cells simply break down into granular matter, and the fluid portion infiltrates the contiguous structure. From what I have said about the local origin of cancer you can understand how it happens that recovery sometimes occurs from enucleation. In Gross's "Surgery" is detailed a case which recovered from encephaloid after the twenty-third operation; and other instances of recovery are not wanting.

*Case VI.*—Mr. George T. M., of White Mills, Hardin county, Kentucky. This man is thoroughly saturated with malaria; he has a poor appetite, bowels constipated, headache, and general malaise. In the left eye he has suppurative keratitis accompanied by powerful contraction of the orbicularis palpebrarum. The corneal epithelium is shaved off the upper half, and in the inferior and outer quadrant of the cornea is a mass of suppurative matter.

He has been treated by Dr. Ashlock, who gave him atropia and morphia as a local application, and iron, quinine, and iodide of potassium constitutionally. He is now evidently better, as there are unmistakable signs of resolution of the inflamed cornea, and the breach of continuity is beginning to be repaired, as is shown by the smooth-bevelled edges of the ulcer.

This is a typical case of suppurative keratitis, nearly always due to malarial poisoning,—at least, as it is observed in this part of the country; and these are the cases which afford the most striking illustration of the therapeutic value of calomel. Whilst quinine is necessary, calomel is likewise essential. I have never yet seen a man suffer from suppurative inflammation of the cornea without a dis-

position to constipation, general malaise, loss of appetite, scanty urine, and other evidences of the constitutional effects of malaria.

After releasing the eye from pressure and friction of the lid by a canthoplasty, I expect to see him recover promptly under the use of calomel and quinine constitutionally, and a continuation of the morphia and atropia locally. Having forced the cornea from the injurious friction of the upper lid, whose lining membrane is somewhat roughened by long-continued inflammation of the cornea, and by its passage over the roughened ocular conjunctiva, which is never absent in cases of suppuration or other forms of keratitis, and particularly in those cases where the iris is also involved, recovery will be rapidly completed.

This disease, no doubt, began in the iris, and with the development of the serous form of iritis there is a proliferation of connective-tissue cells in the posterior elastic layer of the cornea, or upon its surface, thus propagating the disease to the proper substance of the cornea, causing what is commonly called suppurative keratitis, which begins in fact by the effusion of plastic material in the proper substance of the cornea, subsequently breaking down all the affected tissue, leading generally to perforation.

To the treatment employed by Dr. Ashlock, Mr. M. is indebted for his good fortune in escaping that calamity. Under the use now of calomel and quinine for four or five days, until the more violent symptoms of inflammation have subsided, followed by the iodide of potassium or syrup of the iodide of iron, I confidently expect this man to regain his strength and health and have a restoration of the sight of his eye. The amount of the tissue destroyed, the actual destruction of the proper substance of the cornea, will mark the extent of the remaining opacity, which in this case is likely to be so small and so far removed from the vertex of the cornea as to place it out of the line of vision and therefore occasion but little obstruction to sight. The canthoplastic operation which I have just performed gives him immediate relief from the sense of friction, which was a source of great suffering to him before. The stitches introduced are to be removed in twenty-four hours, and in the mean time he is to keep his eyes

constantly bathed in cold water. He goes to St. Joseph's Infirmary, with instructions to remain in-doors until further orders.

*Case VII.*—Mrs. D., of Lebanon, is now 50 years of age, which is above that at which the accommodative power presents any difficulty to the process of testing the refraction. The decline in the accommodative power occurs simultaneously with that of the body in general, and constitutes the earliest sign of senility. She comes to get glasses. But, upon examination with the ophthalmoscope, I find an unsuspected and very interesting condition. She has retinitis pigmentosa, an inflammation of the retina which is always characteristic of constitutional specific disease. She has had a perforating ulcer in the left cornea, and retinitis has existed a long time in the right eye. The disease is probably syphilitic. Galezowski says that the bichloride of mercury given to the production of its constitutional effects constitutes the only successful form of treatment in retinitis pigmentosa; he does not think much of the biniodide of mercury, or of the protiodide, or in fact of any other than the corrosive chloride. He uses the corrosive sublimate in the dose of one-twenty-fourth grain, which, if it act too severely upon the bowels, is controlled by paregoric.

I mention him as authority because I like his papers on retinitis pigmentosa. I believe if there is anything like a specific treatment in this disease, if there is any improvement to be obtained, if there is any power to arrest the disease, that power is found in the bichloride of mercury. Small doses systematically and regularly administered until the gums become tender, followed by the ordinary doses of iodide of potassium, four or five grains, gradually increased for three or four days, until iodism is produced, will yield the best results. These will, of course, be assisted by out-door exercise, salt-water baths, and everything that will tend to keep up a strong and vigorous action of the whole system, and facilitate excretion by the skin, bowels, and kidneys. This patient is now fifty years old; there is no telling how long she has had this trouble. It may have been acquired, although Mr. Hutchinson and Galezowski have expressed the opinion that this is one of the manifestations of inherited disease. They may be correct.

## HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

CLINICAL SERVICE OF PROF. ASHHURST.

Reported by JOHN M. TAYLOR, M.D.

*CASE OF CYSTITIS WITH ENLARGED PROSTATE AND RECTO-VESICAL FISTULA, TREATED BY SIR HENRY THOMPSON'S METHOD OF INTRODUCING A TUBE INTO THE BLADDER THROUGH AN OPENING ABOVE THE PUBIS.*

THIS patient, a man somewhat advanced in years, had been in the hospital several months, suffering from inflammation of the bladder and very great enlargement of the prostate. There was no retention of urine, with vesical distention and secondary overflow, such as is so often met with in cases of prostatic hypertrophy; but, on the contrary, the bladder was very much contracted, the patient micturating on an average once in every half-hour or hour with intense pain, and the catheter not bringing away more than a fluidounce of very offensive and dark-colored urine. The patient himself declared that there was an opening between the bowel and the bladder, and that he had on one occasion passed several grape-seeds *per urethram*; but, as there was no escape of urine from the rectum, and no appearance of fecal matter in his water, this was supposed to be a mistake, though, as it was afterwards found, such an opening actually existed.

Apart from the fact that there was no urinary retention to require the use of the catheter, the employment of this instrument caused increased pain, and hence was not persisted in, and as internal remedies (including ergot and the chlorate of potassium) had utterly failed to give relief, the case was thought to be one in which it would be justifiable to adopt Sir Henry Thompson's suggestion of establishing a direct communication with the bladder above the pubis, an operation which finds its analogies in colotomy for rectal stricture, and in tracheotomy for occlusion of the larynx. This operation has been practised in five cases by Sir Henry himself, with decided, though only temporary, benefit in each instance; and a similar procedure has been employed by Dittel, of Vienna, and by Prof. Keyes, of New York, but, so far as is known, has not been heretofore attempted in Philadelphia.

The patient, having eagerly assented to the suggestion of any operation which might offer even a hope of relief, was etherized and brought before the clinical class of the University on Saturday, November

20, 1880. About three fluidounces of tepid water having been carefully injected into the bladder, the long styleted tube, made by Mr. Gemrig exactly according to Sir Henry Thompson's description, was introduced through the urethra, and made to push up the anterior wall of the bladder, immediately above the pubis. The instrument being then confided to an assistant, Dr. Ashhurst made a longitudinal incision about half an inch in length, exactly in the median line of the abdomen, cutting down cautiously upon the bulbous end of the stylet, which, followed by the tube, was thus made to project through the wound. The stylet being next withdrawn, a tube shaped like a tracheal canula, and two and a quarter inches long, just large enough to fit inside of the large urethral tube, was introduced its whole length into the projecting end of the latter, and, as this was slowly withdrawn, was thus carried into the bladder, its safe lodgment in the viscus being announced by a free gush of urine mingled with the water which had been previously injected. The tube was then secured in place by means of tapes passing around the hips and thighs, and the patient returned to his bed.

The only point in which the operation differed from Sir Henry Thompson's was in the use of a metallic instead of a flexible vesical tube. This modification was decided upon, Dr. Ashhurst said, because he could not obtain any flexible tube which would be sufficiently permanent to be of value, and because the greater facility in cleansing and reintroducing the metallic tube would, he thought, compensate for any risk of its producing undue irritation. To guard against the latter contingency, the tube was made with a movable plate, after the manner of a tracheal canula.

When the patient was visited in the ward, about an hour after the operation, it was found that fecal matter was mixed with the urine which flowed through the vesical tube, thus showing that the patient's suspicion that there was an abnormal communication between the bladder and gut had been well founded. The operation has been followed by no constitutional disturbance whatever, and there has been measurable relief from pain, so that it may be considered to have accomplished what was expected from it. It is hoped that when the patient shall have learned to manage the tube for himself, he will be placed in a

condition of comparative comfort. The enormous size of the prostate must prevent any attempt to relieve the recto-vesical fistula by operative measures, and, indeed, all the circumstances of the case are such as to forbid any expectation of effecting a radical cure.

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## TRANSLATIONS.

**SYMPTOMATOLOGY OF TUMORS OF THE MEDIASTINUM.**—In an elaborate article on this subject, illustrated by several clinical histories of rare cases, Dr. A. Schreiber (*Deutsches Archiv für Klinische Medizin*, Bd. xxvii., 1880, p. 52) gives numerous points in symptomatology which are of considerable importance. Hertz, he reminds us, has said that the appearances presented by new formations of the mediastinum are entirely dependent upon their size, the rapidity with which they develop, their locality, and the pressure which they exert upon the important organs of the thoracic cavity, heart, lungs, trachea, and bronchi, the œsophagus, and particularly upon the larger vessels and certain portions of the nervous system. Small, soft tumors, adds Schreiber, hardly ever give rise to pathological symptoms; the latter do not appear until the tumors have reached a certain size. One of the earliest complaints, difficulty of respiration, at first observed only after unusual exertion, later constant, and sometimes going on to dyspnoea or even orthopnoea, and possibly terminating in suffocation, is found to be due to compression of the trachea and bronchi, or rather of the recurrent vagus. This may give rise to a feeling of compression at a particular point in the neck. At the same time pain in the sternum, usually dull, but sometimes sharp and burning, and which may radiate into the neck and arm, is felt. The disturbances of the general condition which may occur are various. Sleeplessness, usually dependent upon the difficulty of respiration, is one. Pleuritic effusion may prevent the patient from lying on the affected side or even lying in bed at all, as in the case of a patient of Fuller's, who was obliged to sleep kneeling, with his head on his hands, in a bed made especially for the purpose.

The temperature, which is sometimes increased, shows no typical range, and is

probably dependent on some intercurrent disorder; it is not characteristic of the tumors. Loss of appetite and nutrition is at times noticed, probably as a result of the general condition; it is worse if associated with difficulty of swallowing. Attacks of syncope, dizziness, *muscæ volitantes*, etc., are due to unusual circulatory disturbance, and are not met with in most cases. Dry, irritating cough, with mucous or muco-purulent expectoration, occasionally mixed with blood, is among the most annoying symptom of mediastinal tumor. It is due to compression of the recurrent nerve, which also may give rise to weakness of voice through relaxation of the vocal cords, and occasionally œdema of the glottis. Compression of the vagus sometimes causes difficulty in swallowing, hiccough, and vomiting. Occasionally these symptoms may be caused by direct compression of the œsophagus by the tumor. In a case reported by Todd this alone caused death.

With regard to external symptoms, the grayish-yellow complexion of the patient is characteristic. More important is the not infrequent occurrence of cyanosis. The pupils are sometimes asymmetrical or otherwise changed. Rossbach gives a case where pressure upon the middle part of the right supraclavicular region invariably caused sudden dilatation of the pupils. Coolness of the extremities is often noticed, and œdema sometimes occurs. Strumous swellings are sometimes observed.

The respiratory sound is most weakened over the seat of the tumors, as are also the heart-sounds. The pulse is usually small and frequent (100-136 in some cases). Enlargements of the glands are frequently observed.

The skin shows increased sweating, sudamina, etc. The mamma of the affected side may be enlarged, usually being pushed out by the tumor, but venous obstruction may also give rise to such enlargement. Disturbances of sensation, as formication, etc., neuralgia, and paralysis, all due to pressure of the tumor on nerves, are rarer symptoms.

**DIFFERENTIAL DIAGNOSIS OF TUMORS OF THE MEDIASTINUM.**—Schreiber (*Deutsches Archiv f. Klin. Med.* Bd. xxvii. p. 66), in a paper on tumors of the mediastinum, a portion of which we have given above, says that these are to be distinguished from

pericardial effusions, pleuritic exudations, aneurisms, partial infiltrations of the parenchyma of the lung, mediastinitis, and mediastinal abscesses. With reference to pericardial effusions, of course only chronic cases are to be considered. The usual fever accompanying these and also the area of dulness on percussion will serve to distinguish these as well as their clearly-defined limits. Articular rheumatism, Bright's disease, pyæmia, etc., are usually concomitant with pericardial effusion; the apex-beat of the heart is muffled, and a rubbing sound is heard. None of these phenomena occur in mediastinal tumors. The diagnosis is often extremely difficult, however. With reference to the differential diagnosis between mediastinal tumors and aortic aneurism, this refers only to cases where the aneurism is of considerable size and presses against the anterior wall of the thorax,—cases in which there is dulness under the sternum. Here the rarely perceptible resistance of the area of dulness when percussion is made, the visible or palpable pulsation, the usually systolic murmur, the retardation of the pulse in the peripheral arteries; serve to aid the diagnosis under ordinary circumstances. Now and then, however, unusual combinations of lesions may occur which cause great difficulties in diagnosis. Such are the effects of compression on the œsophagus, the larger veins, the recurrent nerve, etc. Also in cases where a firm tumor lies farther back and presses the aorta forward, giving rise to phenomena of pulsation. In one case cited by Schreiber it was impossible for two years, during which the patient was under observation, to find out whether or not an aortic aneurism was present. Pleuritic exudation can usually be distinguished without great difficulty; in case of doubt some fluid may be withdrawn by aspiration. Now and then the two conditions exist together, which adds greatly to the difficulties of diagnosis. Infiltration of the borders of the lungs is very rare, and may be distinguished from mediastinal tumor by careful percussion. Mediastinitis is usually accompanied by fever, etc., and the dulness on percussion is not often so decided.

Although, as has been shown, careful investigation will usually lead to a correct diagnosis of tumors of the mediastinum when uncomplicated, yet when these occur in connection with other troubles it is



almost impossible at times to arrive at a satisfactory conclusion.

#### PREVENTION OF MERCURIAL STOMATITIS.

—Dr. Jules Simon recommends the following preparation to prevent the development of mercurial stomatitis in a course of antisyphilitic treatment:

R "Eau de Botot" (artificial), f3vj;  
Tinct. cochleariæ, f3iiss;  
Tinct. cinchonæ, f3ii;  
Tinct. catechu, f3i;  
Tinct. benzoin., f3ss.—M.

A small quantity is mixed with water and used as a gargle morning and evening and after meals.

#### TREATMENT OF INFANTILE SYPHILIS.—

Dr. Jules Simon, in a lecture published recently in *Le Progrès Médical*, recommends the following course to be pursued. Inunctions with *ung. hydrarg.* to be made every night and morning, alternately, in the armpits, the groins, and the popliteal spaces. Five drops of Van Swieten's liquor to be taken four times a day gradually, augmenting the dose until twenty drops are taken at a time. A wooden or porcelain spoon should be used. This treatment should be continued a long time,—months at least. The medication should not be suspended during the first period, but the dose may be increased or diminished, depending on the progress the patient is making. We must feel our way. When, for instance, the skin of the patient's face regains its transparency, the nose is open, the anal region is smooth, when sleep is natural and calm, the dose of medicine may be reduced drop by drop. At the least sign of return of the skin manifestations the dose of Van Swieten is to be increased. The cutaneous frictions should be managed in the same way, being reduced in number and extent, but never wholly suspended, during the first five months. At the end of four or five months the concomitant internal administration of iodide of potassium is begun. *Syrop Gibert* is the best form to give this: a quarter to a half dessertspoonful may be given daily, much diluted in water and divided into four or five doses. The dose is to be increased or diminished from time to time according to the effect produced upon the lesions. When the infant appears to be restored to perfect health, the medicine may be slowly reduced in quantity and finally stopped, a careful watch being kept against the recurrence of any symptoms.

Dr. Simon does not favor the use of mercurial baths. He thinks that either they are too short and only act locally, or they are too prolonged and tend to enfeeble the child. Besides, there is constant danger of catching cold, to the action of which infants are extremely susceptible. As a lotion, particularly where there are lesions about the anus and buttocks, the sublimate solutions are valuable. Syphilitic infants should be kept in a warm atmosphere and should not be taken out in cold weather. It is hardly necessary to say that the mother alone should nurse her child. Failing this, cow's milk may be employed, although with much less success. By hard work, continues M. Simon, you may succeed in snatching the unfortunate infant from the jaws of death. Do not, however, rest in a false security when it appears cured; guard carefully against relapses. Tell the parents to submit the infant frequently to the inspection of the physician, and then, if the least spot or blemish appear, indicating a tendency to return of the trouble, begin treatment once more. Even quite large children must be watched thus, and must occasionally be placed upon a new course of mixed treatment.

**REFLEX SYMPTOMS IN PATIENTS OPERATED UPON FOR EMPYEMA.**—At a recent meeting of the Société de Biologie (*Le Progrès Méd.*, 1880, p. 846) Dr. Dumontpallier reported the case of two patients operated upon for empyema where certain accidents had taken place some weeks after the operation, when the cure seemed almost complete. In one case, that of a woman, Dr. Dumontpallier injected some tincture of iodine by the opening into the thorax. Scarcely had a few drops penetrated the thorax when the patient suddenly fell into a condition of syncope and remained several minutes without breathing, being brought to with difficulty afterwards. Up to that day the patient had supported the injections perfectly well. The second patient, a man of forty, had been operated upon eighty days previously. The adhesions had been so considerable as to leave only a small cavity containing only a little liquid. At the moment when a little carbolized water was being slowly injected into this cavity, the patient was suddenly seized with general contraction of the muscles on the opposite side of the body. This lasted some minutes, and was followed by incomplete paralysis.

## PHILADELPHIA MEDICAL TIMES.

PHILADELPHIA, DECEMBER 18, 1880.

### EDITORIAL.

#### THE UNIVERSITY OF PENNSYLVANIA.

**A**MONG our miscellany is a paragraph which was penned by one of the trustees of the University of Pennsylvania, and which may therefore be looked upon as a semi-official statement of changes about to be perfected in the organic methods of that ancient and venerable corporation. The old proverb about the foul qualities of a certain bird which does a certain act is, perhaps, a useful although a much abused one; and yet, if it had not been for the public showing of how soiled the family linen was, made some years ago in the pages of *Lippincott's Magazine* and of this journal, it is very possible that the medical department of the University would not now be what it is. The action of the Board of Trustees shows that they recognize the need of changes in the method of management of the University; but, as these changes have not yet been more than fairly entered upon, perhaps it may be well to call the attention of the University authorities, and of the interested public, to certain undeniable facts.

It seems to us very important that it should be generally recognized that the career of the University has been a most lamentable one, one disgraceful in the extreme, either to the community in which it is placed or to those who had charge of it, or else a failure, because of the bad methods upon which its life has been founded and nurtured. The institution is over one hundred years old; it was cradled during the infancy of the great city which envelops it,—a city whose fame is in all the earth. For decades it was the only higher institu-

tion of learning not only in this city of Philadelphia, but also in the State of Pennsylvania. Has it grown with the city? Has it dominated the life of the citizens? As the millions of property multiplied about our streets by the hundredfold, have its coffers been filled? What are the area, population, and wealth of Boston to those of Philadelphia? Omitting the medical department, the growth of which has not been due to the University, what is the University of Pennsylvania, in its influence, to Harvard? It may be said that Harvard has grown because Boston is more cultured. Nay, verily. Boston is more cultured because Harvard has permeated it with its influence. The strong liquor is not strong because the spirit has made the leaven, but because the leaven has made the spirit, though the leaven may increase in the process.

Whilst charities multiplied,—whilst millions were found for orphan asylums,—whilst refuges for the deaf, blind, halt, lame, institutions of every character, grew apace,—for nearly three-quarters of a century practically if not absolutely nothing was donated to enrich the University: so at least it is affirmed.

It is essential that we perceive the weakness, the impotence, in order that we should be able to search out the cause. During the last two decades there has been no lack of energy, of devotion, or of business talent in the Board of Trustees; of their own substance they have given bountifully; they have dared much; they have accomplished much; and whilst they have demonstrated the comparative feebleness of the hold which the institution has upon the community,—the legacy left them by a long line of feeble (to use no stronger word) predecessors,—and have accumulated much of debt, they have made the University a centre which Philadelphia can begin to be proud of; they have laid a foundation upon which to appeal to all friends of education, all patriotic Philadelphians.

We have, perhaps, occupied too much space in stating these facts, but our readers were scholars before they were doctors; and the present seems full of hope, because the recent action of the Board of Trustees is evidence that they perceive the difficulties of the situation, and have the self-abnegation to lay aside power.

The reasons of the lamentable failure of our University seem to us to have their roots, first, in the methods of its government; second, in the method of the appointment of the trustees. The theory of the government of the institution has practically been that each department was managed by its own faculty, superintended by a committee of the Board of Trustees, whose chairman was the more or less indifferent autocrat of the department. Of course, this resulted in the University being not a homogeneous educational community, but a collection of educational villages, between which there might be concord, indifference, or jealousy, the truth being that at the present time many, possibly the majority, of the University professors do not know one another by sight. The recent action of the Board of Trustees ends this. At last this nondescript collection—of which we have been at once so proud and so humble—is to have a real head; and we may hope soon to see all the faculties working together with that *esprit de corps* which comes of union and recognized brotherhood. This is well,—a step in advance so great that it leads us to hope that more will follow.

The second cause of the failure of the University—one not yet remedied, one which has to our thinking been the veritable *fons et origo mali*—is the method of the appointment of the trustees.

They are a self-elective body, responsible to no one, reporting to no one, filling their own vacancies by their own wills. Yet a university must grow, if it grow at all, by the efforts of its alumni; it is chiefly their sons and their friends

who are to fill its halls; it is chiefly they who are to give renown to and extend the influence of the alma mater. Is it the faculties of Harvard or is it the roll of its famous alumni that gives most brilliance to its lustre?

If alumni are to keep alive their interest, to give their money, their influence, and their time to an institution, they must have some control and some representation in the governing board of the institution. The simplest, and therefore it would seem at first sight the best, plan, is to have a *portion* of the Board of Trustees elected by the alumni. In the long succession of years we believe that this would keep the *personnel* of the board uniformly higher than the present plan. Too much praise cannot be awarded to the present governing body, but the history of the University shows the danger, under the present methods, of the formation of cliques and lines of undue influence. It is not this, however, that we desire most to guard against. Our complaint is that at present the best Board of Trustees represent—whom?—themselves, that is all.

More spiritless, and we had almost said more useless, assemblies we have never attended than the annual meetings of the alumni societies; but if it were known that reports were to be read by representatives from the Board of Trustees, and that elections were to take place for such representatives, that general plans of policy, as well as details of execution, were to be discussed, that representatives were to be instructed when questions of sufficient magnitude arose, it would be like opening wells of water in the Sahara: the deadness of the desert would be swallowed up in the fertility, the teeming life, of the oasis.

The charter of the University may require the appointment of the trustees as at present; but the life of the institution is more than the charter. If necessary, let the latter be amended. At the same time, we do not assert that the adoption of the

exact change here approved of is essential; it may be even that, under the present complicated circumstances, it is not the best way of accomplishing its object,—namely, the giving of direct representation to the alumni in the government of the institution.

Alumni of the University, if you love your old alma mater and wish its prosperity, now is the time to meet, to discuss and to express in unmistakable terms what is needed.

It is no secret that Dr. William Pepper has been nominated for the position of trust just created by the Board of Trustees of the University. Without wasting words, we may state our belief that in the existing circumstances the best man that the board could have chosen has been selected. The duties of the position as now arranged are such that they can be fulfilled without the sacrifice of much time, and Dr. Pepper does not expect in any way to relax his efforts either as a member of the medical faculty of the University or as a practitioner of medicine.

#### POTENTIZATION.

PERHAPS the human intellect never conceived an idea sublimer in its absurdity than the homœopathic doctrine of potentization, which may be expressed briefly as the theory that teaches that the differentials of inert substances like chalk are prime forces in the universe. (Our readers will remember, no doubt, from their boyhood studies, that the differential of a vanishing number is that quantity which it is when vanishing, *i.e.*, when it is no longer anything, and yet is not possessed of the proprietary rights and privileges of nothing.)

Some years since, a medical student was complaining to us that his family tormented him by constant efforts to make him leave the University for the Hahnemann Col-

lege. On asking how it was that under the circumstances he had not studied homœopathy, he replied that he had intended so to do, but one day their family doctor took a small vial out of his pocket and said, "Look at this, John: it is my most precious possession. Twenty-five years ago I put a fraction of a grain of chalk in it, and filled up with sugar of milk. Day after day ever since I have used out of this bottle, replacing the contents as they waste with pure sugar of milk, and now I have a most powerful energy for good confined there." The man was sincere, but his imbecile enthusiasm was too great a dose for the gulping power of the boy. He could not believe that the miracle of the widow's cruse of oil should receive in these modern times infinite repetition.

In the *Homœopathic United States Medical Investigator* for October 1 a contributor, with Hollandish stolidity, relates the following

#### "REMARKABLE EXPERIENCES OF AN ACONITE BOTTLE."

"Over thirty years since I got a little aconite leaf at a drug-store. The druggist cut off a little slip not one-half as much as your little finger. I asked him how much for it? He says you are welcome to that little. I put it in a vial holding about two ounces, and filled it with half alcohol and half water. This preparation I used on every occasion of sickness of horses and cattle owned by myself, and many of my neighbors, for about fifteen years. Every creature which took the medicine got well. From five to ten drops at a dose was all that was used, and then not more than three to five doses. Some animals had other medicines after it, but all got well. The vial would get dry by evaporation, or used out, and all that we done was to put in alcohol or water. I gave the vial to a son-in-law of mine, after using it myself fifteen years, having first cured for him a horse sick and down with the colic with it. He has at times had charge of twenty and thirty horses, and when anything was the matter the little aconite bottle came out as the first thing, and generally the only thing. He of late sold out his horses and gave the bottle to the men he sold to, and they use it just the same. No medicine has been added in thirty years, but often filled with alcohol and water. Not one horse died in sickness if he took out of the little bottle. I think the little bottle good for thirty years more if kept filled, and will do just as well as ever. This may appear strange, but it is true. More are killed with medicine than cured."

The theory of potentization and the structure built upon it seem, however, destined to death; and the unkindest



blow has come from a homœopathic medical society. Well may some of our struggling brethren exclaim, *Et tu, Brute!*

The Milwaukee Academy of Medicine (homœopathic) distributed to believers of high potentization carefully-prepared vials of medicine. Each individual received ten vials, nine containing only pellets of milk-sugar, and one having in it globules of a high potency of aconite. The endeavor was to distinguish the medicated sugar by its effects on the human system. Twenty-five believers, residents of twelve different States, sent for and received the vials. Concerning these, the final report, as adopted by the Academy, reads thus:

"Number of tests applied for and sent out, 25.

"Number of tests on which reports have been received, 9.

"Number of tests in which the medicated vial was found, 0."

From which it appears that sixteen of those who undertook the task did not venture on any report, whilst not one of the nine who did report indicated the right vial.

The test and its results have called forth no rebutting evidence of value, only considerable abuse of Dr. Potter, president of the Academy, which is evidence of its truthfulness and value.

## CORRESPONDENCE.

### LONDON LETTER.

THE medical world of London is very quiet at present, and the schools are settling down into their stride for the serious work of the winter session. The improvement in the entry at the London Hospital is marked. Situated at the East End of London, even its able staff failed to attract to it students in proportion to its teaching power. But railway facilities at last brought it within ready reach of the rest of the world; and this, combined with a little extra energy on the part of the governing powers, has begun to tell upon the entry. At Guy's the entry was much larger than was anticipated by the profession in the face of the present imbroglio. Clouds are suspected to be gathering for the London Hospital, as the new matron there just appointed is the lady who recently worsted Dr. Humphry at the Pendlebury Hospital, near Manchester. The pro-

fession is beginning to realize that there is a "screw loose somewhere" in its social position, when the appointment of a matron is regarded as the herald of approaching trouble and probable disaster. However, as people make their bed, so must they lie; and the medical profession is finding out that it is no exception to this law. The profession has not always and invariably with true loyalty to itself put the best man into the vacant post,—a principle which ought to be as conservative as chastity in a woman; and now clouds of gathering storm are to be seen in the distance to supplement the rows which have already taken place. But, be that as it may, the real merits of the profession are too solid for its errors to dim its reputation permanently.

The subject of typhoid fever is being discussed at present from various stand-points. We are all under the impression that typhoid fever is exclusively, or nearly so, communicated from one person to another by means of the stools of the affected person. That fact has been vividly, indeed painfully, demonstrated by various outbreaks, as, for instance, a recent one at Caterham, where an extensive outbreak was clearly traced to the stools of one workman affected with ambulatory typhoid, portions of which found their way into the water-supply of an extensive area, the result being a wide-spread outbreak of typhoid. All who have had experience of country practice know too well how a single case of typhoid, acquired at a distance, comes into a hamlet and is followed by the appearance of several cases in the neighborhood. Here the conclusion is inevitable that the sick person brought the fever-poison, and that from lack of knowledge, perhaps, rather than culpable negligence, the stools, or part of them, are allowed to reach the water-supply and contaminate it. Typhoid fever develops in an endemic form. Now, granting all this as indisputably proved, and as forming the basis of our knowledge of enteric fever, and realizing how such knowledge can be made practically useful in the prevention of its spread, still there are some other matters which must not be lost sight of. Foremost among these is this. If this view of the propagation of enteric fever is allowed to dominate the mind too completely, then there is a corresponding danger of our being forgetful, or practically so, of the other ways by which typhoid fever may be originated. Especially is this danger rendered probable by the prominence recently given to the accepted doctrine as to the etiology of enteric fever, by the attacks on an extensive scale which have occurred in connection with the milk-supply in various localities; and not only in typhoid fever, but in other specific fevers, notably scarlatina. But the other aspects of the production of typhoid fever must not be entirely overlooked.

In a recent letter I pointed out how outbreaks in Germany had been traced to eating meat which was not fit for human consumption, to put it broadly. Now some further evidence is furnished by a thoughtful article contributed by the pen of Dr. R. Bruce Low, the medical officer of health for a rural district in Yorkshire, as to the occasional origin of typhoid. He resides among a primitive people little addicted to migration, and firmly rooted, comparatively isolated; where there are no sewers and no sewer-gas, no water-mains with interrupted or contaminated supplies, but free supplies of pure water from springs issuing from limestone rock. There are there no surface-wells, tanks, or cisterns,—at least in the houses which furnished the fever cases. There was therefore no case originating in the drinking of water contaminated by specific discharges. The district is such as is familiar to the readers of Emily Brontë's "Wuthering Heights," and is far removed from any practical risk of typhoid infection, unless some case of the disease comes accidentally into it,—a matter which would soon be notorious.

One case given is that of well-marked enteric fever developed synchronously in a farmer's daughter and a shepherd residing in a cottage of his own, who alike ate some bacon which was "black and had a queer smell." It is surmised that the bacon was part of a pig which had been the subject of typhoid fever when slaughtered on your side of the Atlantic. This is a matter of considerable interest for the shippers of bacon cured in the Northwest States. In another case the cause of infection is carefully traced to a hide with putrid flesh attached to it, in a farmer who "never got over that smell." More generally interesting is the account he gives of a group of cases where no specific contagion could be traced, but where other factors were in action. In this district the cloacal arrangements are very primitive, and the chief method among the men is voiding their motions in the open air behind a fence, while the domestic arrangement is a privy with a large pit, which usually is rarely, if ever, emptied, and is full of fæces to the level of the seat. Here are motions years and years old; whether breeding infection in the course of time or not is a moot point not yet decided. In corroboration of the view that typhoid-fever germs may be in time developed from successive crops of bacteria, growing in infective power in each generation, he refers to the experiments of Burdon-Sanderson, "that it is possible to proceed from an inflammation of purely non-infective origin to the artificial induction of a process of the most intense virulence." He goes on to infer from this, "The gradual evolution of a contagion is, therefore, a demonstrated fact in science;" and from this we might argue that diarrhoeal discharges received into a foul

garden-privy in the first instance cause further and severer attacks of diarrhoea, the contagion after each attack becoming increasingly virulent, till the summit is reached, and typhoid fever, a specific contagious disease, is produced. In corroboration of this view he gives an example of a double cottage, which was occupied by ten persons (two families). The privies, some twenty yards to the rear, had, in consequence of a dispute, not been emptied for more than twelve months. First violent sickness and diarrhoea, with some bloody motions, showed themselves. There was some fever for several days, followed by rapid recovery. The attack was nearly fatal in three cases out of the seven attacked. Some visitors who remained in the rooms when the sick persons' bowels moved were seized with similar symptoms. So soon as the privies were cleaned out by the sanitary authorities the outbreak ceased. Three persons, males, who never resorted to the privies, escaped completely. He speculates as to the growth of typhoid from beginnings like these by relating a case which was seen by a second medical man and pronounced unmistakable typhoid, where there had been a case ending fatally, and certified as diarrhoea, in the house eleven months before. This case of typhoid ended fatally, and was followed by another case of true typhoid. Here the synthesis of typhoid seems fairly made out.

Some little time ago, when visiting in Somersetshire, I went with my host, a medical man, to see some cases,—one of undoubted typhoid, the other of diarrhoea with pyrexia and prostration,—such as those spoken of by Dr. Low, where the surroundings were very filthy, and fluid filth from a pig-sty found its way into the well of drinking-water till in the sunlight the water was opalescent. Though Dr. Low may not be said to have demonstrated his point beyond the possibility of cavil, it must be admitted that he has made out a case *a priori* so strong that he can fairly demand that country practitioners should investigate their cases of typhoid fever with the view of seeing how few a number are not originated by excreta from some already existing case of typhoid, but are, in some instances at least, bred up from filth and culpable dirtiness of habits. My experience as a country practitioner in the past certainly places me on Dr. Low's side as to the origin of some cases of typhoid fever.

That cases of typhoid coming in from a distance must be rare in that district, and the history palpable enough if occurring, is shown by the following details: "We have the same succession of heather, hills, moors, and bogs, wooded glens and mountain torrents, as in the scenes of 'Wuthering Heights.' Our people believe in ghosts. My predecessor in this practice has been seen (as it is said) more than once since his death. They believe in witchcraft and charms. Calves die from

spells cast by old women. Children take fits from 'evil eyes' being thrown at them, etc. As an example of our seclusion, I may relate an instance. My predecessor was attending a family (on a lonely moor) with diphtheria. The day after he saw them a heavy snow-storm came on, and, on making the attempt to reach the house, he failed, owing to the deep snow-drifts. He managed six miles, but the remaining three baffled him. A whole village set to work, and in five or six days cut a narrow path for him and his horse; but on his arrival he found four or five corpses in the house. Another example: Last winter, in a snow-storm, my colleague was sent for to a lonely house twelve miles off. He sent his assistant, who came back with the news that an operation for strangulated hernia was required. Next day my colleague and his assistant rode the twelve miles through the snow, and reached the house in the afternoon. As it was growing dark, they asked for candles, to afford sufficient light for the operation; but a messenger had to walk a distance of six miles over the snowy moor to the nearest village before he could get light sufficient for the operation. The delay, I regret to say, was against the success of the case, and the patient died." This will furnish the reader with an idea of what "country practice" is in some parts of Old England, and also tells how the neglect of all, or almost all, sanitary arrangements, from ignorance quite as much as indifference, may lead to diphtheria and typhoid fever,—indeed, to those maladies which are notoriously associated, causally, with filthy surroundings.

While on the subject of country practitioners it may be well to consider briefly what Dr. Angus Macdonald, of Edinburgh, has recently said about puerperal fever. Most of us can remember the time when the very thought of puerperal fever filled the medical man's mind with horror and dread. He knew of instances where a doctor had carried with him, in his function as an obstetrician, death to parturient patient after parturient patient, until the grim fact that he was the cause of death was forced upon his consciousness. Then he left his practice for some time, at a ruinous expense, partly from actual expenditure, partly from making nothing during the time, to return to realize the truth that a number of his best patients were dead, and that dismay and distrust reigned in the minds of those who remained. I, at least, can remember well what my father used to think on this subject. A contemporary of his had been the death of some dozen women consecutively, and had to leave his shattered practice for months before he regarded it safe to return. And it would rather surprise us now to hear how slowly the conviction dawned on these men of the past that the doctor was really the infecting agent; also, how dull must have been the apprehension of the moral cul-

pability of remaining at work as obstetricians when death succeeded death. One of the grandest outcomes of antiseptics is the practical abolition of puerperal fever in an endemic form. Dr. Macdonald speaks of these antiquated plans of dealing with the spread of puerperal fever, and points out that now they are superseded. He points to the fact that it is in all cases "a true septic intoxication, a fever of resorption, and differs essentially in no wise from surgical fever." Abrasions and lesions of continuity of the lining mucous membrane of the fæcal tract favor absorption. Micrococci are the infecting agents, it would appear. A solution of one per cent. of carbolic acid is sufficient to destroy these minute organisms. The doctor must be careful to see that his clothes may not carry infection from one patient to another; no ablution of the hands, however perfect, can prevent that source of mischief from being operative. The bare arm must alone, be used in connection with a post-parturient patient. As an evidence of the immunity attainable by proper precautions, he said that in the spring of 1879 he met with a case of puerperal fever in a patient of good social position, where for ten days he personally, twice daily, dressed a vulval ulcer and gave the vaginal douches. During this time he performed craniotomy, put on the forceps high up, practised turning, and extracted an aborted fœtus, without the slightest bad consequences of any kind. Had the remotest bad symptom showed itself he would have desisted from his obstetric labors at once, and without delay. As to his procedures, when called upon to examine or lift a patient suffering from puerperal septicæmia he always takes off his coat and rolls up his shirt-sleeves; he then washes his hands in turpentine or rubs them with carbolic oil. After his work is accomplished, then he washes his hands in turpentine and soap and water, using a nail-brush freely. Then he washes his hands in a five-per-cent. solution of carbolic acid, and finally puts them under a tap of running water. "Considerable importance," he says, "appears to me to be attached to the latter proceeding, as the running stream makes it certain that everything is carried away as well as washed off the hands. If a basin be employed the hands are brought from time to time into contact with any septic matter that might remain undestroyed in the basin." He is careful, however, while advocating the perfect protection afforded by resort to antiseptic precautions, to insist, "Nothing could be further from my intention in this contribution than to inculcate carelessness or do anything which could bring danger to patients or disgrace to obstetricians. But, on the other hand, I am anxious that everything should be done for unfortunate patients suffering from puerperal septicæmia which is consistent with fairness to the unaffected and

to the obstetrician in charge." He does not believe that the abstinence from practice advocated by certain obstetrical authorities is necessary or effective; indeed, he says it is not acted upon by these very preachers of the doctrine,—a rather strong statement.

He goes on to say, "For aimless and haphazard suspension from professional duty I would substitute the most thorough cleanliness and disinfection, believing that in the latter means the real safety of the patient lies. I have published my experience in this matter in the hope that it may encourage others to trust to and practise disinfectant appliances in similar emergencies." This principle of thorough, rapid, and complete disinfection ought also to be practised by nurses and midwives. If practised, he thinks it would not be so often necessary to change the nurses attending upon post-parturient patients. Midwives ought to be educated to use these disinfectant measures, as "time is only a very uncertain element in disinfection." He concludes with a strong expression of opinion that if these disinfectant measures were universally adopted the occurrence of puerperal septicæmia, in both private and maternity practice, would be largely diminished.

J. MILNER FOTHERGILL.

## PROCEEDINGS OF SOCIETIES.

**PATHOLOGICAL SOCIETY OF PHILADELPHIA.**

THURSDAY EVENING, OCTOBER 28, 1880.

THE PRESIDENT, Dr. S. W. GROSS, in the chair.

*Large spindle-celled sarcoma of the sheath of the penis.* Presented by Dr. W. G. PORTER.

JOHN H. HENTON, black, widower for the second time, New York, æt. 44, temperate, was admitted to the Presbyterian Hospital on the 25th of August, 1880, and gave the following history. His health had always been good. He had never had any venereal disease, and he was the father of three healthy children. In March last, while employed as a porter in a large retail clothing-house, he was engaged in moving a very heavy package from a truck to the cellar, and while sustaining an unusually heavy weight, he felt something give way in his groin. He immediately dropped his end of the package, vomited, lay down, and felt so sick that he had to stop work. He went home and remained in bed for several days. He then returned to work, but in a few weeks noticed a tumor in the right inguinal region, which rapidly increased in size. Supposing that he was ruptured, he applied to an instrument-

maker for a truss, who gave him a suspensory bandage. The tumor from this time enlarged very rapidly, and he was soon compelled to stop work, and applied to me for relief. On examination, a large tumor was found filling up the right groin, surrounding the penis, and extending deeply into the perineum. Neither testicle was implicated by the growth. The tumor was heavy and exceedingly hard. There were no evidences of fluctuation about it, and throughout the tumor felt as hard as a fibroid. There was no difficulty in passing water, and a bougie or catheter readily entered the bladder, and the course of the urethra could be easily demonstrated on it. As the man was incapacitated for work and the tumor was increasing in size, its removal was advised, and on the 27th of September, with the advice and assistance of the surgical staff of the hospital and of Prof. S. D. Gross and Dr. S. W. Gross, the tumor was removed. An oblique incision was made over the long axis of the growth, and after a rather tedious dissection by knife and finger the attachment was found to be to the right side of the sheath of the corpus cavernosum of the penis; only at one point, and that a small one, was the cavernous body itself involved. The hemorrhage was slight and was controlled by the ligation of several bleeding points. There was some capillary oozing, which was controlled by the application of hot water. The wound was carbolyzed, a drainage-tube inserted, the lips of the wound approximated by stitches, a compress and bandage applied, and the patient removed to bed. He soon came out from the ether, showed no evidence of shock, and seemed to be in good condition. In the early morning of the next day his belly became tympanitic, and he complained of the wound being tender and sore. The compress and bandage were removed, as there had been no oozing, and the wound was lightly dressed. He passed his urine without the assistance of the catheter. A turpentine enema brought away large quantities of gas. The following day the penis was swollen and the prepuce very œdematous; the belly tympanitic again. Enemas and the passage of a rectal tube failed to give relief. The patient suffered considerable pain; the tongue was dry; the edges of the wound dry, glazed, and erysipelatous; no discharge from the wound or drainage-tube; the penis became gangrenous; the belly remained tympanitic, and the patient died, exhausted, on the 1st of October, four days after the operation. Autopsy showed no evidences of peritonitis or cellulitis, though there was some very fetid gas in the peritoneum, but nothing but the local lesions already detailed to account for death.

Dr. SEILER said that he had made a number of sections from the tumor which had been sent him by Dr. Porter, and on examination had found them to consist of spindle- and round-cells of the large variety, the



former predominating, so that the growth should, in his opinion, be described as a large spindle-cell sarcoma.

Dr. S. W. Gross said that through the kindness of Dr. Porter he had seen the tumor before its removal, and had then regarded it as a sarcoma. The operation plainly showed that it arose from the sheath of the right corpus cavernosum, which is continuous with the superficial perineal fascia, as was first demonstrated by Dr. Buck, of New York, and that it had invaded the tunica albuginea of the corresponding body to the extent of about two-thirds of an inch. He had looked up the literature of the subject, and the only reference he could find to a similar growth was a case recorded by Kochler in the *Charité Annalen*, 1878, and quoted in the *Index Medicus* for July, 1880. In a late posthumous work of Demarquay, published by two of his pupils, and entitled "*Maladies Chirurgicales du Pénis*," no mention is made of any such growths. From this he would infer that sarcoma was a very rare affection in this region, and that in all probability this case of Dr. Porter's was the only one that had ever been reported in this country.

*Hypertrophy of the prepuce.* Presented by Dr. J. E. GARRETSON.

Patient a native of the island of Barbadoes; age, 60 years. Associated with the enlargement and induration of the prepuce there was an apparent relaxation of the tissues of the scrotum, that appendage being some ten inches in length and of very little less width. The hypertrophy of part shown commenced several years back. When in place over the glands the full circumference of the structure seemed involved; when retracted the thickening was seen to be confined to one side. Removal was not attended by any hemorrhage. The case occupied the ordinary time of an operation for circumcision.

*Tumor of mammary region.* Presented by Dr. J. E. GARRETSON.

The tumor shown was removed from the superficial fascia overlying the right mammary gland of a lady aged 40 years. It is hard, lobulated, contracted. The concentration of the growth afforded indication for its removal. The time of development has been about two years. In the absence of anything self-explanatory the tumor is to be classified with the neoplasms.

Dr. S. W. Gross in examining the specimen thought that he could detect a distinct capsule, which would, of course, exclude the idea of carcinoma. As it had been kept some time, however, he might be in error, and would suggest the reference of the specimen to the Committee on Morbid Growths.

Dr. Garretson asked the President if he then considered it to be non-carcinomatous.

Dr. Gross replied that if this appearance of

a capsule was not produced by the condensing effects of the preservative agent, and if he understood Dr. Garretson rightly as to its not involving the structure of the mammary gland, he should most decidedly consider it to be non-carcinomatous.

*Report of the Committee on Morbid Growths.*

—"The tumor removed from the mammary region by Dr. Garretson, and referred to your Committee on Morbid Growths, is found upon microscopic examination to consist mostly of dense fibrous tissue, in which are seen the remains of glandular acini and ducts in a state of atrophy. The growth is an inter-acinous fibroma."

*Nerve-tumor.* Presented by Dr. J. E. GARRETSON.

The egg-like tumor upon the plate was removed from the very centre of the posterior tibial nerve of a gentleman aged 55. The growth is of several years' standing; it is allied to a similar tumor in relation with the outer cord of the lower cervical plexus. A tumor, supposed to be of like character, was dissected from the dorsal surface of the right index-finger. The growth shown had parted the fibres of the nerve wherever it lay, and was the cause of much pain in parts supplied by the sacral plexus of nerves. The patient, himself a professional gentleman, had been treated a long time for rheumatism. The discovery of the tumor in the leg altered the treatment to that for neuroma. The growth removed from the finger is believed to have been an adenoma. The tumor upon the plate is reasonably to be designated a neuroma. It is presented to the Society for microscopical observation.

Dr. Seiler had examined the first growth removed by Dr. Garretson, and had found it to consist chiefly of blood-vessels whose endothelium was in a state of proliferation. The intervascular connective tissue was increased in amount. From such appearances he would class it as an angioma. From a cursory examination of the section from the second tumor, now under the microscope, he would be inclined to consider it a spindle-celled sarcoma, but, to afford opportunity for a more thorough examination, he would ask for its reference to the Committee on Morbid Growths.

*Report of the Committee on Morbid Growths.*

—"A thin section made from the tumor situated upon the tibial nerve removed by Dr. Garretson shows, after staining with carmine, numerous nuclei, which are separated by a very indistinct and granular or slightly fibrillated intercellular substance. In many places the arrangement of the nuclei and cells is that which is observed when a section of very young tendon is examined,—longitudinal rows of cells placed at regular intervals and surrounding a bundle of fibrillæ; at other points transverse sections of the fi-

brillæ have been made, when the stellate lymph-spaces are seen anastomosing with one another. We were unable to find any structure which would indicate the presence of nerve-tissue. The growth may be said to consist of embryonal fibrous tissue."

*Fibroma from the palmar surface of the hand, apparent exciting cause of reflex (Jacksonian) epilepsy.* Presented by Dr. CHARLES K. MILLS.

I am indebted to Dr. L. F. Flick for the opportunity of presenting this specimen, the patient from whom it was removed having been for a long time under his care.

M. S., æt. 15, when four years old, fell down-stairs from a height of five steps, striking on the right palm. The hand was not bruised or cut, but the child suffered great pain in it for several weeks. Six months after the fall, two little growths about the size of a pea made their appearance, one on the palmar surface of the wrist, over the position of the common tendon of the flexor sublimis digitorum, the other in the palm of the hand, over the tendon going to the index-finger, about one-third of an inch from the metacarpophalangeal joint. The tumor at the wrist was painful, and grew gradually for five years until it became as large as a hickory-nut. It was then treated systematically with liniments and bandaging, and in three years more disappeared. The tumor in the palm continued very slowly to increase.

Six months after the first appearance of the growths the child began to suffer from attacks of spasm, at first affecting chiefly the right hand. They recurred usually once in about ten days or two weeks. The spasms gradually grew worse; eventually the right arm and leg and the right side of the face would jerk. For the last ten years she has continued to have seizures, generally at intervals of a week or two, but sometimes oftener. The limbs and face of the right side have always been more affected by the spasm than the same regions on the left. The twitching has invariably begun in the fingers of the right hand, and has been preceded by pain in the palmar tumor. The patient, who has always remained conscious, as the attacks have come on would grasp her right hand with her left, or would call on some one else to do this. Chloral, bromides, and other antispasmodics have been used freely, but without any evident effect.

In February, 1880, she began to have a series of paroxysms much more violent than any she had before experienced. At first the attacks came only more frequently during the nights, especially after twelve o'clock. After a few days, however, they increased in number during the day also, until finally they recurred every two or three minutes day and night, ether, bromides, and other medicines having no effect. Menstruation now set in

for the first time, and at once the convulsions ceased, after having continued as just described for two weeks. She grew stronger speedily, and for four months did not have another seizure. She now again began to have occasional fits. Menstruation was not well established.

Early in September, 1880, a second continuous series of convulsive attacks began. At this time, in addition to her dysmenorrhœal symptoms, her digestion was much deranged. I saw her first, with Dr. Flick, on the 15th of September, and since have seen her frequently both during and between her paroxysms. A curious feature has been that as soon as she would fall asleep an attack would come on, while during her waking moments she would often rest easy. She could sometimes control the spasms by force of will; and a smart slap with the hand would sometimes cause the attack to cease.

The following is a description of the usual character of the attacks, as determined from the notes of Dr. Flick, and from personal observation:

The distal phalanx of the ring-finger of the right hand was first flexed; secondly, a few spasmodic movements of flexion would occur in this finger; thirdly, the other fingers and thumb of this hand would begin to twitch convulsively,—the second phalanges would be flexed, the last extended; fourthly, the clonic convulsive movement would extend the right hand, forearm, and arm, and simultaneously the muscles of the lower part of the right side of the face would become affected with spasm, a tremor also appearing in the tongue during this period; fifthly, the right arm and leg would now become affected with a clonic spasm, causing them to assume positions of flexion, the head, neck, and body being drawn by the spasm, at the same time, to the right, a condition of pleurothotonus being, in fact, produced. The seizures would pass off with a very severe jerking movement of the right shoulder, and a renewal of the twitching of the muscles of the right angle of the mouth. These movements of the shoulder and mouth would sometimes occur only once, just before the close of the attack; more frequently, however, they would take place two or three times in succession. Occasionally the patient would bite her tongue during the paroxysm. She apparently was never entirely unconscious during an attack, no matter how severe it might be. During the height of the convulsion, if her hand was pressed too hard, she would manage to gasp out, "Don't!" or to make some other exclamation.

After trying bromides, morphia, etherization, blistering, etc., without avail, I advised the immediate removal of the tumor. On the 26th of September, Dr. S. W. Gross removed the growth, Drs. Hearn, Kirkpatrick, Flick, and myself being present at the operation. The tumor was found to be a firm, lobulated

mass, three-fourths of an inch long and about half an inch in each of its other dimensions. When it was first exposed, a small nerve-branch could be seen passing over its upper inner edge. It was somewhat firmly attached to that tendon of the flexor sublimis digitorum which goes to the index-finger.

The growth was placed for microscopical examination in the hands of Dr. Carl Seiler, who reported it to be a fibroma.

The following, in brief, is the history of the case for the four weeks which have elapsed since the operation. She has been kept absolutely without treatment for the spasms. She improved at once in her general condition. She has averaged a little less than one attack a day since. The right hand or arm has never been affected in any of these seizures, only a few of which have been severe.

*Remarks.*—I am inclined to look upon the spasms in this case as primarily, at least, reflex, the fibroma of the palm acting as an exciting cause. This seems probable for a number of reasons. (1) The spasms appeared after the fall and the development of the growths. (2) Before the removal of the tumor the spasm invariably began in the finger of the right hand, on the palm of which the growth was situated. (3) The spasms were usually of the nature of monospasms, or unilateral convulsions of the right side of the body. (4) The spasms became much less frequent and severe, and ceased to begin in the fingers of the right hand, after the operation.

The convulsive disease from which this child has suffered has all the characteristics of what has been termed "Jacksonian epilepsy," in honor of Hughlings-Jackson. By a "Jacksonian epilepsy" is meant a convulsive affection confined to a group of muscles, to a limb or to two limbs, or to face and limbs of the same side, and usually commencing in the same way. Consciousness sometimes is and sometimes is not lost. Unilateral convulsions are more likely to be associated with loss of consciousness than spasm confined to the face or to one limb.

Have we in a case like this any real morbid changes in the brain? Without doubt, I think, such changes have taken place. Post-mortem examination would probably reveal inflammatory changes of the cortex, most marked in the middle Rolandic region of the hemisphere. The presence of the tumor in the hand may, of course, be merely a coincidence, and we may have here in the arm-centre of the left side a tumor, cyst, tubercle, or other lesion, irritative in character and the primitive cause of the monospasm. Cases are on record corresponding in their main features, as regards the origin and progress of the spasmodic manifestations, with our case, and in which, after death, small cysts or tumors have been found in the motor zone of the convolutions.

*Removal of left superior maxilla, left malar, nasal, lateral mass of ethmoid and pterygoid processes of sphenoid for tubular epitheliomatous pharyngeal polypus.* Presented by Dr. C. B. NANCREDÉ.

Charles Muscavitz, aged 52 years, a Pole, was admitted into the male surgical ward of the Protestant Episcopal Hospital in the early part of September, 1880. He most positively asserted that he had noticed nothing until two months before coming to me, when his eye began to be protruded. When I first saw him his left eye was displaced outwards and upwards by a firm, hard mass, seemingly involving the internal angular process of the frontal bone, the nasal process of the superior maxillary, and the orbital plate of the same bone to a limited extent. There was no bulging of the infraorbital region, but, the finger being introduced into the mouth, a slight fulness with tenderness could be detected beneath the zygoma. The posterior portion of the hard palate was slightly depressed, while the soft palate was bulged downwards. By carrying the finger behind the soft palate into the pharynx a large, irregular, lobulated mass was detected, completely filling up this cavity, except perhaps towards its right moiety. The nasal process of the left superior maxilla and the nasal bones were pushed upwards and outwards by the extension of the growth into the left nasal chamber. Indeed, polypoid masses could be detected by both the eye and finger, completely filling the left nostril. I diagnosed a malignant pharyngeal polypus. After consultation with my colleagues, I determined to extirpate the growth with the involved bones. The patient having been first etherized, the Fergusson incision was made and the flap reflected. All hemorrhage having been arrested, chloroform was administered in the place of ether, and the operation completed in the ordinary manner, with a few exceptions presently to be mentioned. Owing to the failure of the bone-forceps to divide the zygoma, the whole malar bone came away, from some lateral motion in using the instrument. Only a part of the tumor came away with the superior maxilla, owing to its firm connections with the roof of the pharynx. The portions of tumor left after the removal of the upper jaw were torn away by the fingers or Fergusson forceps, or cut away with scissors. Owing to the able manner in which I was assisted by my colleagues, Drs. Forbes and Hunter, very little blood was lost. One unusual circumstance was the ease with which hemorrhage was arrested, owing to the fortunate circumstance of the stump of the internal maxillary artery projecting some half inch or more, thus admitting of its ligation. Only a very sparing use of the hot iron was requisite. The whole wound was wiped out with chloride of zinc. The case did well, with the exception of sloughing of the cornea, some two weeks after the operation, from secondary

implication of the nerve, either by inflammation or extension, perhaps, of disease into the sphenoidal fissure. Examination showed that the whole left superior maxilla, the left lateral mass of the ethmoid, part of the vertical plate of the same bone, the left nasal, the lachrymal, the left malar, and both left pterygoid processes of the sphenoid had been removed.

*Microscopical Report, by Dr. J. H. C. Simes.*—"The growth, upon microscopic examination, is seen to consist of epithelial cells, forming solid tubes or peg-like prolongations, which branch and anastomose with other similar prolongations. Between the tubes is a small amount of fibrous tissue infiltrated with embryonic cells. In some of the pegs the cells have arranged themselves in a concentric manner, forming, somewhat imperfectly, cell-nests or pearly bodies. This histological arrangement of elements would place the growth under the epitheliomata, and, according to Cornil and Ranvier, with the tubular variety of this class of tumors."

*Polypous tumor of labia.* Exhibited by Dr. H. F. FORMAD.

Dr. U. M. Beachly, of Meyersville, Pa., sent me this interesting tumor for examination, accompanied by the following history:

Removed from a married lady, aged 38, robust health, weight 210 pounds; eight children, all living. The tumor has been developing for four years. Never gave her much pain. It was attached by a pedicle to the right labia pudenda. The pedicle was two and a half inches in length and one-quarter inch in diameter, having a peculiar appearance, resembling the trachea of a small animal. The tumor when removed was two ounces in weight, in external appearance resembling a cauliflower growth, having an uneven surface, covered by a skin, consistency soft and elastic, and in color bright red. On one side of the tumor was a scab which bled freely when removed.

Upon microscopic examination, the tumor shows the structure of a lipomatous myxoma.

Dr. S. W. Gross said that such tumors were very rare, but that Virchow had delineated a pedunculated myxomatous tumor of the labium majus of much larger size than the one just presented by Dr. Formad, and that Paget refers to several examples.

*Metastatic osteoid round-celled sarcoma of the skull, dura mater, and lower maxilla.* By SAMUEL W. GROSS, M.D.

On the 27th of September, 1879, I amputated through the middle of the arm of a boy two years of age, on account of a periosteal osteoid round-celled sarcoma of the left ulna, which measured three inches and a half in length and two inches and a half in width, and began to develop at the age of three months. On dissection of the limb, four sar-

comatous lymphatic glands, none of which exceeded the size of a large bean, were discovered along the line of the brachial artery above the elbow. In my comments upon the case before the Philadelphia Academy of Surgery, October 6, 1879,\* I called attention to the fact that the ulna was rarely the seat of the disease; that the lymphatic glands were implicated in only 6.25 per cent. of the forty-five cases which I had analyzed; that the subject was the youngest on record; that the prognosis of these neoplasms was most unfavorable, since two-thirds of all patients die with metastatic deposits whether they are subjected to operation or not; and that the secondary growths were most common in the lungs, lymphatic glands, and the osseous system.

On the 25th of June, 1880, the child was brought to me with a densely-hard tumor of the right temporal region as large as the half of an ordinary orange. This continued to increase, but the child had been enjoying tolerable health, the only troubles having been complaints of the weight of the head and difficulty in mastication on the right side, on account of a tumor of the right ramus of the lower jaw, until the night of October 25, when it was seized with convulsions, which were of short duration and very frequent, at least twelve having occurred in thirty minutes. These continued, at more prolonged intervals, until noon of October 27, when death ensued after a violent paroxysm.

For the following notes of the post-mortem examination, which was made twenty-two hours after death, I am indebted to Dr. Ames, resident physician in the Jefferson Medical College Hospital:

"Rigor mortis well marked; extreme emaciation; lower extremities oedematous; stump healthy. On the right side of the head there was a tumor, soft on its surface but hard at its circumference, which was limited above by the temporal ridge, and extended one inch below the condyle of the lower jaw. Its basal circumference was sixteen inches and a quarter, and it measured nine inches from the outer angle of the eye to the posterior portion of the parietal bone. The temporal veins were enlarged, and the skin was discolored just behind the ear. A second tumor was situated in the ramus of the right inferior maxilla, and measured three inches from the outer angle of the eye to the angle of the jaw, and three inches and a quarter from the angle of the mouth to the condyle of the jaw. Upon removing the firmly-adherent scalp, a tumor as large as a hickory-nut was discovered at the junction of the parietal and occipital bones, and was connected, through what seemed to be the posterior fontanel, with the interior of the skull. Another growth, of the same dimensions, was seated at the upper and posterior junction of the temporal and parietal

\* Medical Times, July 3, 1880, p. 500.



bones. The left parietal, temporal, occipital, and frontal bones were of a dark-blue color, and the right parietal bone overlapped the frontal bone for a quarter of an inch. All the bones were thin and very brittle. The dura mater was congested, and an ante-mortem clot three inches long occupied the longitudinal sinus. The arachnoid was normal, but the pia mater was deeply congested. The substance of the brain was very soft, and its veins were engorged. A tumor three inches long, three and a half inches wide, and two inches thick occupied the middle fossa of the skull, and the corresponding lobe of the brain was almost diffuent. The tumor itself was firmly attached to the inner surface of the dura mater, and sent prolongations through that membrane to another tumor of about the same size growing from its outer surface. The large tumor of the right temporal bone appeared to originate in its medulla."

All of the smaller tumors are of a brain-like consistence, and do not appear to be the seat of ossific or calcareous deposits. The large tumor, however, is precisely similar to the primary growth of the ulna, and is beset by delicate spicules of bone which radiate from its centre to its circumference. As the specimens have been removed so short a time, there has been no microscopical examination of their minute structure; but I have no doubt that they will be found to be of the same nature as the primary tumor, which consisted of small round-cells contained in a finely-granular matrix.

#### THE SPECIFIC AGENT OF TYPHOID FEVER.

—Prof. Klebs, of Prague (*Brit. Med. Jour.*, vol. ii., 1880, p. 629), believes that he has discovered the micro-organism which constitutes the specific agent of typhoid fever, and develops his views in a paper entitled "Der Ileotyphus eine Schistomycose," published in the *Archiv für Experiment. Pathologie*, Bd. xii. p. 231, 1880. Prof. Klebs has for a long time, assisted by his pupils, been making researches in this direction. He writes that he has been able to find, at the necropsy of twenty-four persons carried off by dothineritis, microbes in various organs,—in the intestinal mucous membrane, in the thickness of the cartilages of the larynx, in the pia mater, in the foci of lobular pneumonia, in the mesenteric ganglia, in the parenchymata of the liver, and generally diffused in the organs which showed the most decided lesions. These micro-organisms showed themselves in the form of rods, about eighty micrometers in length and 0.5 to 0.6 micrometer in thickness. They have been constantly observed in the bodies of dothineritic patients since the attention of Prof. Klebs was drawn to the subject, and they are always absent from the organs, and especially the intestines, of subjects who have died from any other disease than typhoid.

#### PHILADELPHIA ACADEMY OF SURGERY.

MEETING OF NOVEMBER 1, 1880.

The President, DR. S. D. GROSS, in the Chair.

CLUB-FOOT, SPLINT FOR EARLY TREATMENT OF. BY DE F. WILLARD, M.D.

THE splint here shown is one devised by Dr. Doyle, of Syracuse, and while it does not, to my mind, act sufficiently upon the medio-tarsal articulations to make it serviceable in bad cases of deformity, yet its principle is so simple and perfect in action that I deem it of great advantage in a certain number of cases.

It consists of a pelvic band buckled about the body and prevented from turning by shoulder-straps.

From this extends a steel spiral or "flexible shaft," as it is called by machinists, along the outside of the leg, to be fastened into the shoe. This is three-eighths of an inch in diameter, and is held in position by straps encircling the thigh and leg. From the calf to the foot additional strength is secured by a steel upright riveted to the sole of the shoe and jointed at the ankle.

In applying the apparatus the pelvic- and thigh-bands are secured, when, if the case be one of varus, the shoe is rotated *once* inward; the foot is then placed in it and fastened by lacing. It will at once be seen that the constant tendency of this spring will be to uncoil itself into its original position, and in doing this it must carry outward the toes. In valgus the action would be reversed. It is a force exerted gently, constantly, and "coaxingly," awake and asleep, and if increased power be required the shoe can be rotated twice or three times before it is applied to the foot.

A great advantage obtained by its use is the fact that it in no wise interferes with either the motion of the leg or the action of any muscle, save of the ones which it is intended to antagonize. Its tendency to straighten



- A. Spiral steel spring.
- B. Belt around the hips.
- C. Loops to hold spring in place.
- D. Set-screw by which tension is regulated.
- E. Plate by which the spring is fastened to the shoe.

Where but one spring is worn, a strap should be thrown across the opposite shoulder to prevent the belt from shifting.

itself as a whole would, in a slight degree, raise the anterior part of the foot, and to that extent benefit even an equinus.

As I have said, it does not act with much force upon the medio-tarsal joints; yet its applicability to very young children is greatly in its favor, as it can thus be used as a continual assistant to manipulations. As is well known, the majority of cases of congenital varus can be cured by manipulation and stretching, but as the hands of the surgeon cannot be always in service, and as the mother will not do this more than fifteen minutes during the day, it will be seen that a force acting steadily through the remaining twenty-three and three-quarter hours will prove no mean accessory, even though it be not equal to the hand of the surgeon or nurse. Such a splint applied even during the first week of the child's life could do no harm, and if nickel-plated the urine would have but little effect upon it. By the time that three months have passed, and the child is ready for tenotomy, it will frequently be found that no operation is necessary save section of the tendo Achillis.

For pigeon-toed cases this spiral rotator would be most perfect in its action, and the principle could be employed with advantage on any limb which is deformed by rotation upon its long axis. The inventor has used it for torticollis,\* and also employs it after division of tendons in varus and equinus. I like the mode of action of the spiral, and shall certainly give it a full trial. If it could be secured firmly to the upper part of the leg, its rotating effect upon the foot would be exerted to a much greater extent; in its present form both hip and knee are influenced.

Dr. T. G. Morton believes that in very young children talipes varus depends more on the bones than on the muscles, and hence he is accustomed to press the tarsal bones into position with his thumbs at once. Sometimes ether is required during this procedure. This method for very young children he has found very satisfactory. After the bony deformity has been rectified, the mother is directed to manipulate the foot frequently and the surgeon sees that the parts are properly everted by manipulation. Finally, after the varus has been cured, the condition of equinus (when the child begins to walk, say, when a year old), should it exist, is remedied by tenotomy. The spiral rotator of Dr. Doyle would hardly have sufficient power to force even the bones of infancy into the proper position.

#### COMPLETE EXCISION OF THE ELBOW FOR GUNSHOT INJURY, WITH GOOD RESULT.

Dr. R. J. Lewis presented to the Academy a case of extensive excision of the elbow-joint, with the following history. A burglar,

while entering premises, was shot by a gun set as a trap, and the entire charge of small shot and wadding entered the back of elbow. The upper extremities of the radius and ulna were comminuted, and the lower end of the humerus was split vertically and repeatedly perforated by the shot. The large arterial and nerve trunks were uninjured, and it was determined to make an effort to save the limb by making a complete and extended excision.

The section of the lower end of the humerus, which was exhibited, measures three inches in length, and the comminuted radius and ulna were removed to about a similar extent. The medullary cavity was invaded by the section. It is now seven weeks since the operation, and the parts have cicatrized. The motions of the hand are strong and complete, but at the place of the excision there remains a flail-like union, over which the patient has at this time very little control. It seems probable, however, that as the cicatrix contracts and solidifies the bond of union will shorten, become more rigid, and bring the ends of the divided bones more nearly into apposition, so that the muscles of the arm can resume control of the motions of flexion and extension. If this should fail from want of fixation, some artificial encasement supporting the new joint may be available in regaining the usefulness of the extremity.

In cases of complete excision of the elbow where there is a loose flail-like bond of union, some patients attain the power of controlling its movements by contracting all of the muscles which act on the joint, thus bringing the bones into apposition and producing rigidity, and then the excessive action of either flexors or extensors can effect a corresponding movement.

In excisions of the elbow it is important that the ulnar nerve shall be turned out of its groove behind the internal condyle without being divided or wounded. Experience shows that such injury of the ulnar nerve is followed not only by loss of power of the structures to which it is distributed, but there occurs wasting of parts beyond those which are supplied by that nerve, due probably to influences through its peripheral connection with other nerves.

The elbow seems more amenable to successful excision than any other of the larger joints of the extremities, to which the comparatively superficial position of its posterior surface and the narrowing of bones immediately above and below their articular surfaces seem to conduce. The invasion of the medullary cavity of the humerus does not seem to invalidate success.

Dr. T. G. Morton thought he had never seen a more discouraging case for excision, since the whole outside of the elbow was blown off and so much tissue had to be removed. The free drainage from behind was probably an important point in the subsequent result.

\* New York Medical Record, June, 1880.

**TWO CASES OF COMPOUND COMMUNUTED FRACTURE OF THE ANKLE, WITH LUXATION; RECOVERY WITHOUT OPERATION.**

These cases were presented by Dr. T. G. Morton, who gave the following histories:

Anton W., aged 24, a coppersmith, was admitted May 4, 1880, with a compound comminution of the left tibia, with compound luxation of the ankle. In the foundry in which this man was working, a swinging copper kettle fell from its chain, striking him upon the outer side of the left ankle, causing the above injury. The open wound was three and a half inches long, running across the inner malleolus, evidently caused by the end of the tibia, which was thrust through the skin; the articulating surface could be seen; the heel was thrown far backwards and upwards, and the foot was also everted, but the fibula was intact. Loose fragments of bone could be felt in the wound, and there was not much bruising of the parts.

Dr. Hunt removed two fragments of the articulating surface of the tibia, washed out the joint with carbolized water, tied two small vessels, introduced drainage-tube, and covered the vent with charpie wrung out of carbolized oil. He then suspended the limb loosely in a fracture-box, having applied plaster bandage from the knee to the toes, allowing vent for tube.

May 7, plaster bandage had to be cut on account of swelling. There was free suppuration, with much redness and joint swollen.

June 12, bran dressing applied, and, as pus had bagged and collected behind the outer side of the ankle, an opening was made.

July 2, leg removed from bran; wounds healing. At the present time the man can walk very well, and shows a good recovery without operation.

The second case, Thomas D., aged 50 years, was admitted to the Pennsylvania Hospital, June 28, 1880, with compound luxation of tibia and comminuted fracture of fibula, with the joint freely opened. During a street-brawl he was thrown down with his left foot caught in a cellar-door, and fell sidewise while the foot was thus entangled. The tibia was protruding one and a half inches through a wound over the malleolus three inches in length. There was considerable hemorrhage, though the main vessels were uninjured.

The tibia was reduced, and irrigation with a weak solution of permanganate of potassium commenced as the line of treatment. This was continued for more than two weeks, when a carbolized-oil dressing was substituted. Subsequently a few fragments of bone were removed from the outside of the limb, evidently from the fibula.

The patient was discharged cured, with a good limb, during October, and is presented for the examination of the Fellows of the Academy.

Dr. William Hunt said that the first case

was an exception to the dictum given at the time the paper of Dr. Brinton, advising amputation, was read. He at first intended to amputate, but had decided to try conservatism, and the patient recovered. The man nearly died, however, during the course of the treatment, and it may be that this case, by inducing us to attempt conservative surgery in other instances, will cause numerous deaths.

Dr. C. T. Hunter mentioned two similar cases under his care at the University Hospital, where cure resulted without operative interference. They were worse in appearance than the first case presented by Dr. Morton. If the vessels are intact he believed that it was usually well to make conservative efforts without operation of any kind, since the improved methods of treating such cases, by antiseptic dressings and drainage, allow much to be done in this way that formerly was impossible. He mentioned also a case of gunshot wound of the knee followed by cure without operative interference. The general plan of treatment in such instances is by immobility, which is the most important point of all, through drainage and irrigation. Immobility cannot be obtained by the fracture-box, but the fixed dressing does accomplish it.

Dr. R. J. Levis was of the opinion that the non-operative plan of managing such injuries was opposed to the usual experience of surgeons.

**PULSATING TUMOR SITUATED BELOW THE BEND OF THE ELBOW.**

Dr. R. J. Levis introduced a patient who presented a pulsatile tumor situated below the bend of the right elbow. The history was indefinite. There was less pulsation on the radial side of the arm than on the ulnar. The radial pulse was perceptible; the ulnar was not. Pressure on the brachial artery arrested pulsation in the tumor, but did not render the diagnosis much clearer. For two weeks the patient had had a great deal of pain in the part, which showed considerable superficial redness. The case seemed like an aneurism involving the ulnar artery bound down by deep fascia, but might be malignant disease of great vascularity, especially as spontaneous aneurism in this locality is almost unknown. The man also had a large enchondromatous tumor attached to the thorax over the cardiac region.

The Fellows were asked as to their experience of aneurism in this situation, but none of those present had ever seen aneurismal dilatation in this region except as the result of traumatism.

Dr. William Hunt expressed his opinion that spontaneous aneurism here is rare, because the brachial artery slips laterally when flexion occurs at this joint. The artery rolls or slides inwards nearly an inch, and thus avoids being pinched. The popliteal artery

has no such lateral motion, and is frequently the seat of aneurism.

Dr. S. W. Gross believed the case, on superficial examination, to be a round-celled pulsatile sarcoma.

(To be continued.)

## GLEANINGS FROM EXCHANGES.

**TREATMENT OF FIBROID TUMORS OF THE WOMB BY ERGOT AND CHLORIDE OF AMMONIUM.**—Prof. Goodell, in a paper read before the Medical Society of the State of Pennsylvania, says, "There is no question of the occasional benefit derived from the persistent use of ergot, which, by constricting the uterine walls, cuts off the blood-supply of the fibroid. But, while I have repeatedly seen the tumor grow much smaller under its use, I have also seen the remedy do more harm than good. Ergot is best administered hypodermically, and preferably in the subumbilical region of the abdomen, where it gives least pain, and where its skin-stains are best concealed. Bonjean's purified extract of ergot, in the proportion of fifty grains dissolved in three hundred minims of distilled water, is for this purpose a very trustworthy preparation. One or two hypodermic syringefuls is the dose, which should for several weeks, or even months, be deeply injected once every day." In one case, where the patient dreaded any surgical interference, and even objected to hypodermic injections, Dr. Goodell decided to try, by the mouth, a combination of ergot and ammonium chloride. She daily took from twenty to forty drops of the former, and ten grains of the latter. After eleven months of this treatment she came to see him in last March, and he was astonished at her improved appearance. Her hemorrhages had wholly ceased, and so reduced in size was the fibroid that, to discover it, careful examination was needed. Yet, on the other hand, ergot, however administered, will occasionally not only do no good, but will greatly increase the hemorrhages, especially when the tumor lies under the mucous coat of the womb and projects into its cavity. Then, again, there are peculiar idiosyncrasies which cannot bear ergot in any form or in any dose. Such persons are either greatly nauseated by its use, or they complain of intolerable headache, and the remedy must be withheld. Further, the use of ergot is not wholly without danger. Through the squeezing which the tumor gets from the ergotic contractions of the uterine walls necrosis may take place, and this, while curative, is liable to cause blood-poisoning through absorption of putrilage. Twice has Dr. Goodell met with a metro-peritonitis set up by the violent contractions of a womb made vulnerable by the presence of a growth in its wall. In one of these cases, that of a multiple fibroid, the

issue was fatal. Despite these drawbacks, however, especially when combined with ammonium chloride, it is so efficient an agent in mitigating the more exacting symptoms arising from a uterine fibroid that its use should always precede every other treatment.

**RADICAL TREATMENT OF FIBROID TUMORS OF THE WOMB.**—In the paper above quoted, Prof. Goodell says, after discussing the use of ergot, that where ergot, together with its staunch ally, ammonium chloride, has been tried and found wanting, the radical or surgical treatment must be brought into use to remove these growths. He adds that, having performed enucleation by avulsion fourteen times, he can speak in positive terms of its value. His method of operating is as follows. First, seize the tumor with a strong fenestrated polypus-forceps, or with a volsella-forceps whenever the growth is too smooth and too glib to be securely held by the former instrument. He prefers the fenestrated forceps, because, being without teeth, it is not only safer than the volsella, but it does not have to be opened so widely, and, therefore, needs less room. The tumor being firmly held, the loop of a wire *écraseur* is slipped over the handle of the forceps, and then bent backward towards the operator, so that the beak of the *écraseur* shall first enter the uterine cavity. When the beak touches the fundus of the womb, the wire is coaxed up beyond the claws of the forceps, and as much higher up as possible. The slack of the wire is next drawn in, and its free end secured to one of the cross-bars of the *écraseur*, so that a half-crushing and a half-cutting movement shall be secured. The mucous coat alone is now cut through as flush with the uterine wall as possible. The fibroid is then wrenched from its bed, by traction and by a twisting movement made both with the *écraseur* and the forceps, while firm suprapubic pressure is kept up by the hands of an assistant. Sometimes the seized portion will break off. Then the portion left behind must be caught, noosed, and treated, if possible, in precisely the same manner.

Twice has he been foiled in trying to remove the whole tumor in this way. In these cases the projecting portion of the fibroid was shaved off flush with the wall of the womb. But the portion left behind was in a few days so pushed out, or enucleated, by the uterine contractions as to enable him to remove it by a second operation. Subperitoneal fibroids are not amenable to any radical treatment per vaginam. If pedunculated, they can be treated like ovarian tumors, by laparotomy. Sometimes they are removable by enucleation through an abdominal incision. In one case Dr. Goodell obtained perfect success by removing the ovaries and thus artificially bringing on the change of life.

**INDICATIONS IN OPIUM-POISONING.**—Dr. Kane, in a chapter devoted to the subject in his work on "The Hypodermic Injection of



Morphia," speaks at length of the treatment of opium narcosis. He tabulates all the remedies usually found of benefit in these cases, and gives the indications for treatment, as follows:

- To aid to establish respiration.
- To stimulate the heart.
- To produce general stimulation.
- To counteract soporific effects.
- To produce diuresis.

He believes opium and belladonna mutually antidotal in certain particulars only, and cites the experiments and conclusions of many well-known writers upon the subject. The value of coffee, or its active principle, is also discussed.

A CASE OF POISONING BY DUBOISIA.—E. L. Holmes, of Chicago, reports the following case (*Chicago Med. Jour. and Exam.*, November, 1880). A patient at the Illinois Charitable Eye and Ear Infirmary, during convalescence after Graefe's operation for cataract, was provided with a small bottle of sulphate of duboisia, gr. j to 3j, in place of sulphate of atropia, which caused considerable conjunctival inflammation. On the 27th of April, about nine o'clock in the evening, he took by mistake a "teaspoonful" of the solution. It cannot be determined whether the teaspoon was quite full. The patient at once informed other patients near him that he had taken the wrong solution, but concluded to await the result before reporting to the nurse. In about ten minutes there was dryness of the throat, and in half an hour a peculiar sensation in the legs, then in the thighs, arms, and other parts of the body, as if they were asleep. At the end of three-quarters of an hour, or more, the patient could scarcely talk or stand. Strange to say, not till this time did it occur to the patient or those around him to call the nurse. An active emetic was at once given, with the apparent effect of entirely relieving the stomach of its contents. Without delirium the patient rapidly passed into a state of unconsciousness, and remained in this condition till about five o'clock in the morning. He complained for two days of muscular weakness in the legs and arms, and especially noted a peculiar jerking action of the muscles of the arm in extending the hand to grasp a glass or other object. Dr. Holmes saw the patient at midnight. He was lying quietly, breathing naturally, but in a stupor from which he could not be aroused. The face was not specially flushed, although the mouth and tongue were remarkably dry. The temperature, as determined by the thermometer, had been normal. The pulse varied from 108 to 112. Some time previous to this, before unconsciousness became quite complete, the patient made efforts to sit up in bed. The pulse always fell to 80 when the patient sat up, and increased on lying down. No other symptoms were noticed. An ounce of brandy was given through the night. Morphia was not given as an antidote.

DOUBLE CYSTIC KIDNEY WITH RENAL CALCULI.—From a Danish source the *British Medical Journal* of October 30, 1880, takes the report of a man 37 years of age, who had first voided a renal calculus in 1871 and another in the autumn of 1872. Since that time his health had been good, but sometimes he had a feeling of weight in the loins and discharged a little gravel. On July 1, 1879, he took cold, and soon noticed that the daily quantity of urine diminished, until the 8th, when there was suppression. He was admitted to the hospital on July 9; his bladder was then empty. In the course of the next night he voided about seven ounces of urine with his stools. He complained only of soreness in the region of the right kidney. The urine could not be examined until the 15th, when it was found to contain much albumen. On that day symptoms of uræmia set in, and he died on the 16th. At the necropsy the kidneys were found to be both greatly enlarged, the left, however, more than the right, and both presented almost complete cystic change. The renal parenchyma remaining in the interspaces between the cysts had a yellow-gray turbid appearance. The pelvis of the right kidney was much dilated and contained a large nodulated calculus, the lower part of which was rounded and covered in the orifice of the ureter, which was dilated. The left ureter, at a distance of about two inches from the kidney, was completely blocked up by a calculus of moderate size; below this the canal was completely strictured by indurated connective tissue, scarcely allowing the passage of a fine sound. Above the stone the ureter was dilated, and the pelvis and calices especially were greatly expanded.

Dr. Axel Key, who examined the specimens, thinks it remarkable to find such extensive changes in the kidneys of a person who had enjoyed relatively good health up to a fortnight before his death. He regards the cystic change as having been principally congenital, and as having no connection with the formation of the renal calculi and the consequent obstruction to the flow of urine. The renal parenchyma, which was found between the cysts, had been sufficient for the function of the kidneys. When the renal concretions began to be formed, hydronephrosis was gradually developed, and in connection with it a chronic nephritis with interstitial and parenchymatous changes, which went on for a time without producing any marked disturbance, until at last an acute exacerbation set in and rapidly caused death.

ATROPIA IN CHLOROFORM ANÆSTHESIA.—A correspondent of the *British Medical Journal* (October 30, 1880), referring to a previous communication on this subject by Mr. Schäfer (see *Medical Times*, November 20), says that the subject has been for some years worked out by Professor T. R. Fraser, of Edinburgh,

who has shown atropia to be a cardiac stimulant, advisable when chloroform is to be given. It stimulates the heart, not only indirectly, by lowering the conductivity of the cardiac terminations of the vagi, and thus, of course, diminishing their inhibitory power, but also directly, by stimulating the intramural motor ganglia of the heart, and possibly, also, by raising the excitability of the accelerator nerve to the heart from the cervical sympathetic ganglia, and perhaps it may even stimulate the cardio-motor centres in the medulla oblongata. Dr. Frazer considers it advisable to combine with the atropia a little morphia, say  $\frac{1}{16}$  to  $\frac{1}{8}$  grain of sulphate of atropia and  $\frac{1}{16}$  to  $\frac{1}{8}$  grain of acetate or hydrochlorate of morphia. These are injected about fifteen or twenty minutes before the administration of chloroform is begun, and by this means (1) not only is the patient in a less nervous state when the inhalation is commenced, but (2) less chloroform is required, and (3), moreover, a very objectionable evil is got rid of, or, at all events, ameliorated,—viz., the emesis which is apt to occur with chloroform. In the cases in which the correspondent of the *British Medical Journal* has seen this method followed there has been no vomiting whatever, although in some the inhalation was considerably prolonged.

**THE TREATMENT OF TAPEWORM.**—At a recent meeting of the New York Pathological Society (*New York Medical Record*, November 20, 1880) Dr. Tauszky described his treatment as follows: Three ounces of pomegranate-root are soaked for twenty-four hours in eight ounces of water. This is then boiled down to three ounces, to which are added three ounces of the ethereal extract of male fern, one and a half drachms of sulphuric ether, two drachms of fluid extract of valerian, one drop of croton oil, and one and a half ounces of honey. The patient then abstains from all food save herrings and onions, and also from water. The dose of the medicine given is one-third every half-hour. As soon as the patient feels intestinal contractions or colic, whether this is after the first, the second, or the third dose, one ounce of castor oil is administered hourly in cold black coffee, without sugar, until the worm is expelled. In case the vermicide mixture causes nausea, lemonade, ice pills, or strong, cold black coffee, without sugar, relieves it. The preparatory treatment is a dose of castor oil forty-eight hours before taking the worm medicine, so as to empty the bowels thoroughly of feces. Milk diet exclusively for twenty-four hours following the laxative, and the twenty-four hours before taking the mixture. The patient abstains from food and drink, except that he occasionally takes a little salad, made up of salt herring, onions, and garlic. [If the doctor can get him to take such a mess, which we much doubt.—ED.] After the worm is expelled, mucilaginous

food only is taken for a day or two, and a starch and laudanum enema in case of tetanus.

**PARALYSIS OF CRANIAL NERVES IN CONGENITAL SYPHILIS.**—At a recent meeting of the Pathological Society (*Lancet*, vol. ii., 1880, p. 657), Mr. Nettleship brought forward a living specimen, a girl of stunted growth, having distinct evidence of congenital syphilis. She was affected on the right side with partial anæsthesia of the parts supplied by the first and second divisions of the fifth nerve, complete paralysis of the sixth nerve, and partial of the third and fourth. There was also opacity of the cornea, old iritis, choroiditis, and probably retinitis; it was impossible to tell the exact condition of the optic nerve, but vision was fair. The right eye was apparently markedly smaller than the left, which might perhaps be connected with an obvious asymmetry of the bones. There was old keratitis and choroiditis on the left side, but no paralysis. He was unable to say whether the seat of the lesion was in the orbit or the cranium; there were no symptoms of disease in either. The President, Mr. Hutchinson, stated that there had been many recent additions to our knowledge of brain and nerve disease in inherited syphilis. He himself had published two or three cases of ocular paralysis, but it was bilateral, giving evidence of a central origin: he had never met with a case where there was distinct evidence of pressure on the trunks of nerves.

**POISONING WITH HOMŒOPATHIC GRANULES OF "NUX."**—Dr. Gaspar Griswold (*New York Med. Record*, vol. ii., 1880, p. 374) gives the case of a patient who was accustomed to take five homœopathic granules of "nux" repeated two or three times for sick-headache. On one occasion, however, she went beyond this dose, and took fourteen granules, taking it five times—the dose amounting to seventy granules in all—in the course of an hour and a half. Alarming symptoms of strychnia-poisoning supervened, which were finally overcome and the patient recovered.

**PERFORATION OF MEMBRANA TYMPANI BY ASCARIS LUMBRICOIDES.**—Dr. Lewis W. Reynolds (*Lancet*, vol. ii., 1880, p. 653) was called to see a little girl who two weeks before had vomited several round-worms and about the same time suffered severely from dyspnœa and intense pain in the chest and abdomen. Shortly before the doctor's arrival the patient had vomited two worms, and three more were discharged from her nostrils, her nose bleeding first for three hours. Four grains of santonin powder were prescribed, to be taken at bedtime, after taking which four worms were passed per rectum for the first time. Three or four hours after taking the second powder, and having previously suffered from an intense earache, a neighbor discovered a worm protruding from each ear and both ears bleeding; the same day three others came away

from the ears, others were discharged from the ears and also from the bowels, seventy-four in all. The patient afterwards showed excoriation of either meatus and a large perforation of both membrana tympani. She finally recovered.

**INFLUENCE OF ALCOHOLIC BATHS ON THE PERSPIRATORY FUNCTION OF THE SKIN.**—Dr. S. Wassalief found that, after the skin had been thoroughly rubbed with alcohol, hot baths induced much more profuse perspiration, exceeding sometimes four and five times the amount of water lost, without previous treatment with alcohol. Hence the two processes should always be combined when there is indication for extraction of a considerable quantity of water through the skin. Dr. Wassalief explains the action of alcohol by an irritation of the sensitive and perhaps also of the secretory nerves of the skin, and also by the removal of fat from the surface of the skin and the glandular pores.—*New York Medical Record*; from *Wratch.*, 1880, No. 13.

**FATTY TUMOR OF THE LARYNX.**—At a recent meeting of the Pathological Society (*Lancet*, vol. ii., 1880, p. 656) Mr. Sydney Jones showed a fatty tumor as large as a Tangerine orange, with a pedunculated attachment to the right aryteno-epiglottidean fold. It was met with in a man forty years of age. On opening his mouth, nothing abnormal was seen, but when he gave a peculiar gulp the tumor was brought up and lay on the dorsum of the tongue. It was removed by freely dividing the mucous membrane of the pedicle and tearing it out. A small cyst was found in it.

**PRURITUS VULVÆ.**—Dr. Tauzsky recommends the following (*New York Medical Record*, vol. ii., 1880, p. 387):

R Pulvis acaciæ, ʒii;  
Bals. Peruvian., ʒi;  
Ol. amygdalæ, ʒiss;  
Aquæ rosæ, ʒi.—M.

Apply freely with a camel's-hair brush eight or ten times a day to the itching part.

## MISCELLANY.

**UNIVERSITY OF PENNSYLVANIA.**—We learn that the trustees of the University contemplate using the chance afforded them by the interregnum in the line of provosts to make some organic changes in the duties of this office and that of vice-provost. For many years the vice-provost has had no duties of moment, or only in the absence of the provost; but meanwhile the duties of the provost have multiplied, so that it has become desirable, in electing a gentleman to fill this place, to assign to the vice-provost, under the authority of the provost, many of the details of administration, and to leave to the provost certain work which will

not necessitate his giving to it most of his time, and will thus enable the trustees to select a competent presiding officer out of the ranks of the learned professions. Under this arrangement the provost would preside over trustee meetings and sit on important committees. He would interest himself with the general policy of the university, with the inter-relations of its schools, and foster and extend its relations to the State and city, as well as on all social occasions act as its representative. Such labors would not be inconsistent with the work of a profession, so that we hope soon to learn that the trustees have succeeded in finding among us some worthy representative both of our State and of the alumni of the school. The new appointee will be in reality a chancellor, and it is said that this change of title was at one time contemplated; but it was deemed best that the old and honored title of provost should be retained.†

**THE LAW OF SLANDER AS APPLIED TO PHYSICIANS.**—Mr. W. H. Whittaker has in a recent number of the *American Law Register* of this city a very learned paper upon the above subject, from which we extract the conclusions:

"The question still remains, when do the misrepresentations of a physician's practice in a particular case warrant the presumptions of damage? It is allowed that slanderous words alleging gross ignorance generally, or such ignorance or thorough incapacity as unfits him for the proper exercise of his profession, are actionable *per se*. To say of a physician, 'He is a quack' (Pickford *vs.* Gutch, Dorchester Assizes, 1787); or, 'He is an empiric and a mountebank' (Vin. Abr., Act. for Words, S. a. 12); or, 'He is a quack; if he shows you a diploma it is a forgery' (Moises *vs.* Thornton, 8 Term Rep., 303); or, 'He is no doctor; he bought his diploma for fifty dollars' (Bergold *vs.* Puchta, 2 Thomp. & C., N. Y., 522); or, 'He is a drunken fool and an ass, and never was a scholar' (Cawdrey *vs.* Tetley, Godb., 441); or, 'He has killed six children in one year' (Carroll *vs.* White, 33 Barb., 615); or, 'It is a world of blood that he has to answer for in this town through his ignorance. He was the death of J. P. He killed his patient with physic' (Tutty *vs.* Alewin, 11 Mod., 221); or, 'I wonder you had him to attend him. Do you know him? He is not an apothecary; he has not passed any examination. He is a bad character; none of the medical men here will meet him. Several have died that he has attended to, and there have been inquests held upon them' (Southee *vs.* Denny, 1 Ex., 196). In all these cases it has been held that damages are inferable without proof; but to say of a physician, 'He is so steady drunk that he cannot get business any more' (1 Ohio, 83, n.); or, 'He is a twopenny bleeder' (Foster *vs.* Small, 3 Whart., 138); or to charge an allopathic physician with having met homeopaths in con-

sultation, and that in the opinion of the profession it was improper to do so, and against etiquette; and, further, that in the opinion of the profession it was disgraceful to meet a homœopathist in consultation (Clay *vs.* Roberts, 8 L. T., N. S., 397); or to charge him with adultery, not necessarily touching him in his profession, without showing that it was connected with his profession (Ayre *vs.* Craven, 2 Ad. & E., 2), have been held not actionable *per se*.

"While the authorities are generally agreed as to charges of gross ignorance or incapacity in the exercise of the duties of the physician, it is not easy to determine what words are actionable in themselves in special instances. In analogous and even in precisely similar cases, the courts are divided. Where the words were, 'He killed my child; it was the saline injection that did it' (Edsall *vs.* Russell, 4 M. & G., 1090); or, 'He has killed my child by giving it too much calomel' (Johnson *vs.* Robertson, 8 Porter, 486), they have been held actionable *per se*. And, on the contrary, the words, 'He has killed his patient with physic' (Poe *vs.* Mondford, *supra*); or, 'In my opinion the bitters A fixed for B were the cause of his death' (Jones *vs.* Diver, 22 Ind., 184); or, 'He gave my child too much mercury, or made the medicines wrong through jealousy, because I would not allow him to use his own judgment' (Edsall *vs.* Russell, *supra*), have been held not actionable in themselves.

"In the examination of these cases, it will be found that where the physician is charged with killing his patient, the words have been held actionable on account of the imputation of crime which they import, and the only case in which such language has been held not actionable is that of Poe *vs.* Mondford, of an early origin.

"How such words necessarily import the crime of murder or manslaughter, in the absence of any expression of intention, is not quite clear. . . . Perhaps it would be more fatal to resort to legal proceedings in any case. If the physician does, he is compelled to show special damages, for none will be inferred. This alone would cause many to hesitate before bringing an action. The difficulty attendant upon proving damages, the length of time intervening between the publication and consequences of a slander, would deter many from the prosecution of the slanderer.

"As the cases now stand, one may bring almost any charge of misconduct against a physician in a particular case, without subjecting himself to an action for damages *per se*, provided it does not come within the category of a statutory crime or impute to him general incapacity."—*Cincinnati Lancet and Clinic*.

A MYCOLOGICAL SERENADE.—The following verses, by Mr. Wilson, North Kimmund, Aberdeen, were read at the dinner of the

Cryptogamic Society, held during its meeting in Glasgow:

TO CLARA MARCHELLA DELICIOSA.

O lovely Clara, hie with me  
Where Cryptogams in beauty spore,  
Corticiums creep on trunk and tree,  
And fairy rings their curves restore;  
Mycelia there pervade the ground,  
And many a painted *Pileus* rear,  
Agaric rend their veils around  
The Rana! overture to hear.

Where gay *Peizize* flaunt their hues,  
A microscopic store we'll glean,  
To sketch with camera the views  
In which the *Ascus* may be seen.  
Beneath our millimetric gaze  
*Sporidia's* length will stand revealed,  
And eyes like thine will trace the maze  
In each *Hymenium* concealed.

*Æstivum* tubers we shall dig,  
Like *Suidæ* in Fagian shade,  
And many a *Sphæria*-sheltering twig  
Will in our vascula be laid.  
For hard *Sclerotia* we shall peer,  
In barks and brassicaceous leaves,  
And trace their progress through the year,  
Like bobbies on the track of thieves.

While sages deem *Solanum* sent  
To succor *Homo's* hungry maw,  
We'll prize it for development  
Of swelling *Peronospora*.  
We'll mount the *Myxogaster's* threads  
To watch *Plasmodium's* vital flow,  
While *Capillitia* lift their heads  
Generic mysteries to show.

I'll bring thee where the *Chanterelles*  
Inspire a mycologic theme.  
While *Phallus* in the shadow smells  
And scarlet *Amanita* gleam;  
And lead thee where *McMoorian's* rye  
Is waving black with ergot spurs,  
Where many a *Trichobasium* dye  
Gives worth to corn and prickly burs.

And when the beetle calls us home  
We'll gather on our lingering way  
The violaceous *Insolome*  
And russet *Alutacea*;  
The brown *Boletus edulis*  
Our fishing-baskets soon will fill;  
We'll dine on fungi fried in bliss,  
Nor dread the peck of butcher's bill.

## OFFICIAL LIST

### OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM NOVEMBER 26 TO DECEMBER 11, 1880.

BROWN, J. M., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for one month, with permission to apply for three months' extension. S. O. 264, Department of the Missouri, December 2, 1880.

COUES, ELLIOTT, CAPTAIN AND ASSISTANT-SURGEON.—Relieved from duty assigned him in S. O. 134, July 3, 1876, from A. G. O., and to report in person to the Commanding Officer, Department of Arizona, for assignment to duty. S. O. 251, A. G. O., November 26, 1880.

O'REILLY, R. M., CAPTAIN AND ASSISTANT-SURGEON.—The extension of his leave of absence on account of sickness, granted him August 16, 1880, still further extended six months on Surgeon's certificate of disability. S. O. 259, A. G. O., December 7, 1880.

KING, J. H. T., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for four months. S. O. 253, A. G. O., November 29, 1880.

DE LOFFRE, A. A., CAPTAIN AND ASSISTANT-SURGEON.—Relieved from duty at Camp on White River, Col., and assigned to duty at Fort Wallace, Kansas. S. O. 269, Department of the Missouri, December 8, 1880.

HALL, WILLIAM R., CAPTAIN AND ASSISTANT-SURGEON.—Assigned to duty at Camp on White River, Col. S. O. 269, c. s., Department of the Missouri.